2452.

BOSTON MEDICAL

# Kansas Medical Journal.

VOL. III. TOPEKA, KANSAS, JANUARY, 2891. NO. 1.

## New Method of Producing Abortion.

BY C. C. BRADLEY, M. D.,

DEMONSTRATOR OF ANATOMY IN THE KANSAS MEDICAL COLLEGE, TOPEKA.

[Reported to the Academy of Medicine and Surgery, November 4. 1890.]

Case of Eva M——, age 20, colored, American, single. At about 3 o'clock Sunday afternoon, September 7, I was called to see one Eva M——, who it was said had shot herself. Upon arriving I found the patient on her back on a bed, suffering very little from shock, extremities warm, pulse 100. Examination showed a wound evidently made by a bullet, "the tissues in the vicinity being considerably powder-burnt," about four inches to the right of and on a line with the umbilicus, which was bleeding but little. Patient had been seen by another doctor before I saw her, who had given her a dose of morphine.

To complicate matters, she was six months pregnant. A temporary dressing was placed on the wound, and some ¼ gr. powders of morphine left.

The history of the case was, briefly, that the girl had been sitting in a low rocking chair in the next room, and had shot herself with suicidal intent, with a 32-calibre revolver, holding it directly against her abdomen.

Dr. Williamson was called in consultation, and we saw her together about five o'clock, concluding it to be a probable case for operation, the patient was sent to the hospital, and the consent of her friends and relations obtained to do whatever was thought best.

At about eight o'clock Sunday evening patient was seen by Drs. Munn, Alexander, Williamson and myself, and in view of her symptoms, which were, pulse 120, dorsal decubitus, with thighs flexed on the abdomen; restless, anxious expression, and a considerable amount of pain, notwithstanding the fact that she had taken a ½ gr. of morphine since the shooting. An exploratory operation was decided upon.

The patient was chloroformed, and a probe was passed, which at first seemed to pass downward between the muscles to Poupart's ligament, but upon changing the position of the thighs, and relaxing the abdominal muscles, the wound was found to be a penetrating one, and an incision was made in the median line. The abdomen was found full of blood and numerous small clots. Upon examination a bullet wound was found in the right side of the fundus of the uterus, just in front of the right Fallopian tube. This wound was oozing some, but upon being closed with three Lambert's sutures, this oozing was checked. Fine carbolized silk was used for these sutures on account of the greater belief in its antiseptic qualities. Cesarean section was proposed but discarded, there being thought to be not sufficient ground to justify it. A careful examination failed to reveal any wound of exit in the uterus, or any wound of the intestines. The abdomen was carefully cleansed with hot water and closed with silver wire. A drainage tube inserted in the median line, and another in the wound of entrance of the bullet.

The operation was performed by Dr. Munn, and was completed at 12:30 Monday morning, September 8. The patient stood the operation well, was placed in bed, pulse 98, extremities warm. Was given ⅜ gr. of morphine hypodermically during the remainder of the night.

Patient was seen at 10 o'clock on Monday, September 8; temperature normal, pulse 101. A mixture of magnesia sulphate, and aromatic sulph. acid was ordered, so that patient received 60 grs. of sulph. of magnesia every 2 hours; opiates as necessary; milk and stimulants.

September 8, 5:30, p. m., temperature 101°, pulse 106; no symptoms of peritonitis; ½ gr. morphine, hypodermically, had been taken during the day. Bowels had not moved.

September 9, 10 a.m.; had thrown off six months' fœtus during the night; labor easy; temperature normal; pulse 100; salts mixture continued; opium as necessary; the dressing being soiled was changed; by mistake on the part of the nurse patient had received only one-fourth amount of salts prescriced; dose increased.

September 9, 5:30, p. m.; temperature 99°; pulse 120; no peritoneal symptoms; continued salts and opium as necessary.

September 10, 10:30, a. m.; temperature normal; pulse 108; patient comfortable; had taken ⅜ gr. morphine hypodermically during night; salts mixture continued.

September 10, 5:30, p. m.; temperature 99°; pulse 106; bowels had not moved; patient comfortable.

September 11, 10 a. m.; temperature 99⅖°; pulse 88; bowels moved once, large watery passage; had taken ⅛ gr. morphine during night. Milk and stimulants ordered more regularly and oftener.

September 11, 8:30 p.m.; temperature 100°; pulse 100; bowels moved freely, five watery passages; patient very comfortable.

September 12, 10 a. m.; temperature normal; pulse 100; Bowels moved freely during night; patient comfortable: no opiates were given; drainage tubes removed; had taken milk and stimulants regularly.

September 13, 10 am.; temperature normal; pulse 98; bowels moved freely; had taken 1 qt. milk, 1½ oz, whisky, in last 24 hours; superficial sutures remained.

From this time the patient continued to improve; the sutures were all removed on the eighth day, the wounds healing by first intention; on the tenth day a slight increase in temperature was noted; upon examination a small collection of pus was found about the wound of entrance where it had been powder-burnt; this was opened and drained of a small amount of pus. The patient then went on to recovery, and was discharged from the hospital Sunday, October 5, four weeks from date of entrance, cured.

Patient is now engaged as a domestic and doing the ordinary work, including washing, and has no hernial protrusion or other signs of weakening of the abdominal walls.

## Vaso-motor Coryza.

*Read before the Northern Kansas Medical Society, Seneca, November* 13, 1890.

BY GEO. C. IRWIN, M. D., SABETHA, KAN.

That the importance of the nose and its diseases, as physiological factors in the production of reflex neuroses is not generally appreciated, is obvious to any one conversant with professional habits, and who has given the subject attention; and it is not to be wondered at when we consider how recent are the methods of examination and treatment now followed, and how great the advancement has been since their adoption.

With the aid of speculum, head and rhinoscopic mirrors, those parts which were hitherto unknown regions comparatively now become familiar, and pathological conditions such as hypertrophies, hyperæsthetic areas, polypi, deflected septum, and foreign bodies and growths, are plainly visible.

While a certain degree of skill is necessary for the use of these methods, they are not beyond the ability of any physician of ordinary tact, and no excuse exists for their being neglected. In diseases of the eye it is different, for there the technical knowledge and skill required are such as to demand the entire and undivided attention of its devotees. The reflexes of this region have been so much written about, and are so often discussed, that their importance must be realized by all who have given them any attention. Among them we find asthma, hay fever, vertigo, headache, disturbance of sight and hearing, any of which, unless remedied, cause prolonged suffering and distress.

Studying the anatomy of the nose from the writings of Gray, McKenzie, Bosworth and others, we find it to consist of two wedge-shaped cavities extending from the nostrils to the posterior nares, their inner walls consisting of the smooth face of the vomer and car-

tilages of the septum, their outer wall being formed by the superior maxillary, ethmoid and palate bones. Imposed upon this wall we find the so-called turbinated bones, scroll shaped, which are designed to increase the surface over which the mucous membrane is distributed. The floor is formed by the smooth surface of the palate and superior maxillary bones. These cavities are lined by mucous membrane, a typical membrane lining every cavity of the human body which communicates with the external world. The office of this membrane, wherever found, is to secrete mucus, which acts simply as a lubricant. By provision of nature this membrane is endowed with no more secreting structure than is necessary to provide sufficient mucus to keep it soft and pliable. In addition to this membrane, there is found beneath it, on the faces of the lower and middle turbinated bones, large plexuses of blood vessels, the turbinated bodies, which furnish, according to recognized authorities, about 5000 grains of water for the moistening of the inspired air in every twenty-four hours. The necessity for this apparatus is found in the fact, that without it the integrity of the lower air passages would be sacrificed, they not possessing the power of secreting this amount of moisture to prepare the atmosphere for admittance into the lungs. That these bodies may be regulated in their functions of supplying this moisture as demanded by variations in the degree of humidity to which they are subjected, one day being dry, and the next the air surcharged with moisture, they are placed under the care of a delicate mechanism called the vaso-motor system of nerves, found in the middle coats of all the arterioles, which displays its energy by a moderate contraction of the muscular coat of the artery, which is constantly met by the dilating force of the blood-pressure within. An exact balance never occurs between these forces, but in health neither one becomes permanently excessive. This condition, called vascular tone, is regulated by separate nervous supplies, viz., vaso-constrictors and vaso-dilators, and one of the effects of a disturbance of this equipoise is found in the condition called hypertrophy. Frequent repetitions of acute coryza at short intervals are sufficient to produce permanent swellings of the mucous membrane in the nasal cavities at the most pendent portions, viz., the lower edge of the inferior, and sometimes of the middle turbinated bones; and they are sometimes found on the septum.

These are divided, according to their location, into anterior middle and posterior hypertrophies. The respiratory region, which includes all the surface below the upper third of the middle turbinated bone, is covered by a highly vascular membrane, which is exceedingly sensitive to local or peripheral causes; this sensitiveness residing in the terminal filaments of the sensory nerves distributed over its surface.

Sajous, in describing the more sensitive portions of this membrane, divides it into areas, viz., anterior, middle and posterior, located respectively at the anterior, middle and posterior extremities of the lower and middle turbinated bones, and claims that certain irritants, peculiar to each separate individual perhaps, coming in contact with one or more of these sensitive areas, cause the peculiar symptoms called by the sufferers hay fever, and it is not necessary in this paper to discuss them. We find that there must be an external irritant, a susceptibility in the patient to become affected by it, and lastly. a diseased or sensitive area or areas through which the sufferer is affected by this irritant. Each of these propositions are easily susceptible of proof. By dilating the nasal cavities of a sufferer, and touching the mucous membrane in the different areas mentioned, the characteristic symptoms of the disease will be invariably provoked.

By elimination of one of the three elements necessarily present to produce the disease, we are able to prevent a recurrence, and the least difficult for the physician to accomplish is that of resorting to a treatment which will destroy a sufficient quantity of the redundant sensitive tissue to insure, witn the assistance of resulting inflammation and cicatrization, its complete reduction. This insures an organic alteration of the mucous membrane. Of the many modes of treatment for this disease, all but this one, so far as I know, have been failures; but speaking from experience, I

have found this to give marked relief in many very obstinate cases. It goes without saying that all abnormal conditions of the nasal cavities, such as marked hypertrophies, polypi, exostoses, &c., must be eradicated before instituting the treatment, which consists in the cauterization of the sensitive areas in a degree sufficient to destroy the redundant tissue. The means employed should be either caustic acids, cautery or snare.

The only one of these of which I can speak knowingly is the acid treatment; and after using the nitric, acetic and chromic acids, give the latter the preference. Before its use, having explored the cavities with a probe, and located the sensitive spots, cocaine in solution is applied on pledgets of cotton until anæsthesia is produced; a flat silver probe is first warmed, then applied against one or more of the crystals of pure chromic acid. Enough will adhere for two or more applications. This gives rise to but little pain, and its application should be limited to a small area, and renewed three to six times as the case may require.

It has been said, and truly, that it is not the great but the small things we accomplish that makes the successful physician; and although treatment of this disease may seem trifling to us, still the man who gives relief from its distressing symptoms is entitled at least to gratitude and recognition if he realizes nothing more substantial.

My experience in this treatment justifies me in saying, that if it is begun and persevered in for three or four weeks before the so-called hay fever season arrives, so that complete cauterizations of the entire sensitive areas can be accomplished, relief is sure to follow. The relief of reflex asthma, so often caused by the same condition of the nasal membrane, under the same treatment, has been also as successful as it was surprising.

---

THE *Weekly Medical Review* says that the Emperor William has bestowed on Prof. Koch the Grand Cross of the Order of the Red Eagle—said to be the first time that this decoration has been bestowed upon any one who did not possess the preceding classes of the order. It is aptly remarked that many a Knight can be created by the Emperor—but can he create another Koch?

## Aspiration of Bladder by the Dienlafoy Method, with Report of a Case.

*Read before the South Kansas Medical Society, at Peabody, November* 18, 1890.

BY O. B. WHITTECAR, M. D., PEABODY, KAN.

In searching for the best method of evacuating the bladder, when from any cause the natural outlet becomes obstructed, and the cavity of the organ cannot be reached per urethra, I am surprised that so few of our comparatively modern writers should touch so lightly on the *pneumatic* method; and as excellent an author as Holmes does not mention it at all, and Hamilton simply calls attention to it in a brief note.

Keyes' late work on "Genito-Urinary Diseases," is the first authority that it has been my pleasure to consult, who boldly places the Dienlafoy method of pneumatic aspiration, not only side by side with the cystotomies by puncture with trocar and canula, but in a large majority of cases places it ahead.

Deneffe and Van Wetter have collected and tabulated 306 cases of puncture of the bladder as follows: 97 cases of rectal puncture with trocar and canula, with 11 deaths; 152 supra-pubic punctures with trocar and canula, with 6 deaths; and 57 cases of supra-pubic aspirations, and *no* deaths.

Dr. Bennett, in the Annuals of the Universal Science, vol. i., issue of 1888, says that "aspiration of the bladder for the relief of the retention of urine, can only be resorted to with absolute safety for cases in which the walls are presumably healthy;" and he bases his statement on the fact that a case occurred in his practice, where extra-peritoneal rupture of the bladder took place as a result of an aspiration. To me, viewing this statement from a theoretical standpoint, Dr. Bennett occupies untenable grounds, from the fact that in the case on which he bases his statement, the bladder ruptured from the puncture of an aspirating needle—and it is presumed he used one suitable to the occasion—reason would suggest the probability of a more unfortunate rupture in case a larger instrument had been used.

Dr. Keyes, in advocating the Dienlafoy operation makes this exception, and in the following language: "Sometimes supra-pubic puncture, for the purpose of establishing a permanent outlet for the urine in cases where it is inexpedient or impracticable to re-establish the natural right-of-way, in such cases the aspirator is not suitable, for permanent tubes must be placed to be worn by the patient as long as required."

Dr. Keyes fully describes the technique of the operation, instruments used, &c., in his late work.

In advocating the pneumatic method of evacuating the bladder, I beg to report the following case:

The patient was a gentleman, 74 years of age, weighing about 140 pounds, spare in feature, vigorous and active for one at his time of life, but inclined to self-will and indiscretion in the general care of himself. I had been his physician for some eight years, and had, on several occasions, been called to relieve him of retention due to enlarged prostate, and had never experienced any special trouble in introducing the catheter—in fact the obstruction to the normal flow was so slight that I had taught the patient to introduce the instrument himself, which he, as a usual thing, did quite skillfully.

On December 22, 1886, I was called to see him, and found him suffering intensely from retention, and on questioning him found he had not passed water for forty-two hours. Also learned that he had been making repeated efforts to relieve himself with the catheter, and that he had lost considerable blood from the urethra as a result, but failed to enter the bladder.

On attempting to introduce the catheter I found the urethra extremely sensitive, and the membranous and prostatic portions greatly swollen, and on reaching the prostate found it enormously enlarged, especially the middle and left lateral lobes. It would be putting it mild to say that my confidence in my ability to introduce a catheter was greatly shaken, when, after two hours of careful effort with instruments of various sizes, kinds and patterns, I signally failed to enter the bladder. I then gave my patient one-half grain of morphia, ordered a hot sitz-bath, and drove to consult Dr. C. A. Henry, of Fostoria, Ohio, who was an expert in the use of a catheter.

On arriving at the patient's home we found him more comfortable than when I left him—he still being under the influence of the morphia. Deeming it best to have the patient under perfect control we administered an anæsthetic, and while under its influence we each made careful and persistent effort to introduce the catheter, until we both felt that further effort in that direction was useless, and would only increase the obstruction caused by the already-congested and swollen prostate.

Now, as the distention of the bladder had reached a point where we felt that further delay would be hazardous to the integrity of the organ, we prepared to aspirate, and chose the supra-pubic point rather than the rectal, for the following reasons:

1. Because of the anatomical relations of the parts—the distended bladder being free from any peritoneal covering at that point.

2. Because of the difficulty of reaching the bladder through the rectum, around and posterior to the enlarged gland.

3. Because the patient assumed the dorsal position entirely when in bed, and we wished to have the wound in the bladder at the upper side of the organ, in order to lessen the danger of seeping of urine through the wound, and infiltration of the tissues therewith, and a possible subsequent peritonitis therefrom.

My aspirator consisted of the ordinary two-ounce glass barrel with its metal fittings, and having a double nozzle with an *out* and *in* current, regulated at the will of the operator by a rotary valve; sufficient rubber tubing to connect the needle with the instrument, and the instrument with the basin. Choosing a point immediately supra-pubic, and in the median line, we boldly plunged the aspirating needle into the bladder. On measuring the urine after pumping it away, I found we had five pints.

Our patient having rallied some from the anæsthetic during the preparations for the operation, was semi-conscious at the time of operating. After regaining full consciousness he complained of no pain that he could attribute to the operation, and suffered in no way

excepting a burning sensation in the region of the prostate.

After letting our patient rest for about one hour, and thinking that possibly the great distention might have been a factor in the obstinate obstruction, we again made careful effort to penetrate the natural outlet, but with no better success than before.

I now prescribed one-fourth grain doses of morphia to be used when necessary to control pain; ordered hot sitz-bath every four hours, and promised to see him in twelve hours.

In the morning found he had had a fairly good night, but was now suffering great pain again from retention. Bladder distended and plainly outlined, but to a much less extent than on the day before. No evidence of peritonitis, either from local manifestations, circulation or temperature. This being the case, I thought best to again evacuate the organ through the needle, and this time concluded not to use the anæsthetic. The patient stood the operation without moving a muscle, and I drew a full quart.

I will not tire you with a daily report of the case, but simply say that owing to the absence of any trouble arising from the operations, and to the presence of intense inflammation of the prostate, I did not attempt to use the catheter for three days, but aspirated about every twelve hours. At the end of three days I again made careful effort to introduce the catheter, but found it impossible to do so.

About this time, although the general condition of the patient did not indicate the presence of cystitis to the point of suppuration, yet pus and epithelial debris began showing plainly in the urine. I then began washing out the bladder with hot solutions of boracic acid, by simply reversing the current through the aspirator.

This flooding of the bladder with the hot solution after each aspiration, I continued to do so, until I had aspirated *seventeen* times in the space of one week. After the seventeenth operation, and while the organ was empty, I finally succeeded in entering the bladder with a hard rubber catheter, by first softening about three inches of the end of the instrument in hot water, and by withdrawing the stylet about 1½ inches after having introduced it down to the prostate.

I now again washed out the bladder, and a large amount of muco-purulent matter, mixed with epithelium, came away.

I now secured the catheter in situ, and after arranging a plug to the instrument, and instructing the patient how to manipulate matters, I left him.

On calling the next day I found the old gentleman bright and hopeful. From this time on there was no further need of aspirating, and the only complications that arose in the case were a mild cystitis, that seemed to be caused by the presence of the catheter in the bladder, and a mild orchitis, that was probably due to the frequent introduction of the instrument. I allowed each catheter to remain in the bladder three days, when it was removed and replaced by a fresh one.

On the thirty-fifth day of his trouble I permitted the patient to attempt the introduction of the catheter himself, and after some difficulty he succeeded, and from this time on till the fifty-ninth day, he succeeded in waiting on himself by aid of the instrument, but not a drop of urine could he pass without it.

On the fifty-ninth day, and after a persistent effort to have it do so, the urine began passing in a normal way, and continued to do so until I left Ohio for Kansas, which was some four months after dismissing the case.

I since learn that he had no further attacks of retention, and died some eighteen months afterward from apoplexy.

In presenting this case I claim nothing original, either in operation or treatment, but wish simply to call the attention of the profession to the ease with which Dienlafoy's operation can be performed, and the freedom, in my case, of all unpleasant after-troubles.

DISCUSSION.

Dr. Harris related how in one case, with the patient anæsthetized, and being unable with a dozen different catheters to enter the bladder, the patient not having passed any urine for over thirty-six hours; and having no aspirator he improvised one by cutting the sinker off of a household or bulb-syringe, and tying in a hypodermic syringe needle. The next day, having procured an aspirator, and

after failing with the help of Drs. Shelley and Tucker to enter the bladder with catheters, aspirated again. Think it was a case of spasmodic stricture, as he informed me the next day when I went to see him, that he had wet the bed full some time in the night. Had left him quinine to take every three hours, as expected to have a case of urethral fever. He was down town in a day or two all right. With cleanliness (which is asepsis) no more danger in aspirating than giving an injection with a hypodermic syringe.

Dr. Whittecar—The Dienlafay aspirator is simply to evacuate, not as a prostate remedy.

## Morphinism.

*Read before the South Kansas District Medical Society, at Peabody, November* 18, 1890.

BY DR. NOLDER.

Mr. President and Gentlemen:

Next in order to alcohol, opium and morphine are habitually abused to a greater extent than any other narcotic. The habit of taking narcotics, whether medicinally or as a mere matter of indulgence, is apt speedily to become confirmed. The physiological dose more or less rapidly loses its power to affect the nervous system in the ordinary way.

Tolerance increases with increasing doses, and in a comparative short space of time poisonous doses are taken with impunity as far as immediate danger to life is concerned. The toxic effects of the poison are shown in characteristic perversions of the functions of the nervous system and of the mind. A condition is established in which the ordinary functions of life are properly performed only under the influence of the habitual narcotic, and in which its absence results in languor, depression, and derangement of bodily and mental processes. The habit, once established, thus makes for itself a constantly recurring plea for its continuance.

Nature is ever emphatically reminding us that we must not abuse the powers for good, which she places in our hands. Opium, which has unquestionably been the means of saving many from excruciating pain, and even death; and is absolutely indispensable in the treatment of acute inflammatory affections may, in the hands of the thoughtless and weak, become a curse to the individual.

According to history, the opium habit appears to be a disease of comparative modern times. The drug itself was undoubtedly used in ancient times, but not in the United States to any extent, until Wood of Edinburgh devised the hypodermic syringe.

Pain holds the chief place among the influences which predispose to the formation of the opium habit. By far the greater number of cases have taken origin either in acute sickness in which opium, administered for the relief of pain, has been prolonged into convalescence until the habit has been confirmed, or in chronic sickness, in which recurring pain has called for constantly increasing doses of opiates.

Over seventy-five per cent., probably, of all cases of the opium habit in this country, on the continent and in Great Britain, originate in the way just mentioned. The rest are led into the habit either for the purpose of indulging in a purely sensuous enjoyment, or they contract the habit through inability to control an appetite which is, unfortunately, the outgrowth of a feeble organization transmitted to them by heredity. Nearly every asylum contains, side by side with inebriates, chronic morphinists; the only reason for whose habit seems to be a defective and demoralized will power.

The morbid anatomy of the organs of the opium habit is at present but little understood. The most constant pathological action of opium is the paralyzing of the function of the various secretory glands. The gastro-intestinal tract is generally among the first to suffer from indulgence in the habit; gastric catarrh, with the characteristic lesions of that disorder; the delayed and diminished secretions of the gastric juice causes imperfect and delayed digestion. The ingesta passes through the stomach in a half-digested state, and produces the usual consequences of congestion. This imperfect action of the stomach, attended as it is by faulty assimilation, exerts a marked depressing influence on the entire animal economy. The usual symptoms of malnutri-

tion show themselves; the red blood-corpuscles diminish in number; the person becomes sallow, and his complexion acquires a pale, ashy hue; the appetite fails; the muscular system becomes flabby, and the power of endurance is greatly diminished.

The question of the mental and moral responsibility of those addicted to the opium habits merits consideration. It is obvious that a person who is suffering mental disturbance, the result of an opium debauch, is practically in the same condition as the drunkard, who, while under the influence of alcohol, labors under a temoprary mental alienation.

The prognosis of the opium habit is not particularly favorable. The length of time a person has indulged in the habit; the existence of some neuralgic, rheumatic, or other painful affection; or, the existence of inherited dyscrasia, by which he becomes a victim to a morbid craving for stimulants; all become prominent factors in the prognosis.

A weakened nervous system, defective will power, carrying with it diminished resistance to morbid appetites and stimulants, would be, then, a strong factor in the prognosis of this or that case of opium habit, and when this faulty diathesis does appear the prognosis is always bad.

Two methods of treatment have been suggested: The sudden deprivation and gradual reduction; the human organization, as we know from surgery and midwifery will, in general, submit more easily to sudden and energetic treatment, even when acting powerfully, than to a milder influence. In patients suffering from some chronic pathological complaint, requiring the use of narcotics, or in persons weak or exhausted from bodily or mental afflictions, the gradual reduction is more humane and rational than the plan of sudden withdrawal. The reduction of the dose is a matter of much importance, but must vary with the individual case.

I will now report a case and I am done: Mr. R——, aged 32, came under treatment August 25. He had been using morphine with a hypodermic syringe for about two years, and when he commenced treatment was using ten grains a day; he also had been using cocaine for about six months, and when he commenced treatment was using ten to twelve grains a day. He was pale, thin, and anæmic, scarcely able to walk across the room without aid; he had to be constantly increasing his dose. If he did not keep his system under the influence of these drugs he became despondent, and his bowels would take on an active, watery diarrhœa.

The gastro-intestinal tract was so irritable that the lightest form of diet would cause his bowels to bloat and start violent cramps, which would again call for another hypodermic.

The patient was very despondent when not under the influence of cocaine. He thought his system could not stand the course of treatment, but when he realized his awful condition he said he would try; consequently the cocaine was stopped at once, and for forty-eight hours the patient was allowed his hypodermic of morphia, which he used quite freely; still he was fretful and peevish.

On August 27 the hypodermic was taken from the patient, and he was limited to six grains of morphia, in doses of two-thirds of a grain at a dose. The morphia was now reduced two-thirds of a grain each day until September 9, when no morphia was given. Nourishment was given in small quantities quite frequently, consisting of milk, Mellen's food, oysters, &c.

The patient was very restless and nervous during the reduction of the first two-thirds of the amount of morphia taken daily. When the last third was being reduced he became vicious, then delirious. He was now put on sulfonal in twenty grain doses, which produced calm and quiet sleep. He was kept under the influence of sulphonal, and slept most of the time for three days.

On September 16 he sat up nearly all day, and from this time on the patient was given twenty grains of sulphonal at night until he could sleep without it. He has improved rapidly, looks and feels well, and says he has no desire for either morphia or cocaine.

DISCUSSION.

Dr. Furley—Think the old adage, "All morphine eaters are liars," is true. Mentioned case where a patient in the hospital, a morpho-

maniac, claimed to be doing well on curtailment of the drug, succeeded in stealing enough opium, mixed with morphine, to kill himself.

Dr. Hill—Thinks the profession is too much inclined to overlook this class of cases; moral suasion has a great deal to do in effecting a cure. Cited a case where a man came into his office asking for strong counter-irritants, to be applied to spinal column, saying he was poisoned with opium, and knew the treatment he required; confessed to being addicted to the habit. Patient promised to abandon the drug, and would boast how brave he was in quitting, but still kept up the use of the drug.

Dr. Klippel—Physicians are to blame for the increase in the use of it.

Dr. Boyd—I stand before you a victim to an overdose of morphia, through the carelessness of a physician. Three hypodermic doses were given to control the pain of a pleurisy; the last after I claimed to be feeling easier; was under the influence of it about twelve hours. They filled me full of atropia to counteract effect of the morphia, and fearing they had got atropia poisoning, and injected my legs full of ammonia to annul that. As a result had abscesses; have varicose veins, and am crippled for life. In addition to the other treatment they walked, rolled and tossed me. You may judge what effect that had on my pleurisy. Would insist on physicians being more careful in its use. When in Denver a lady sent for me one night, saying she wanted a dose of morphia for the headache; said her husband was a physician and gave her that for it, so I gave her a dose. Passing the house the next day I stopped to inquire how she was, and found her comfortable. On coming down stairs I met a gentleman who, I learned, was a physician, and was treating her for the opium habit. It turned out that she would employ one doctor to treat her, and call in others unbeknown to him to give her morphia; she had been in the hands of quite a number that way.

Dr. St. John gave history of a case where, on being sent for, patient asked are you a homœopath? No Mam! Well, I want no homœopath for this pain in my head; I want a good dose of morphine. Gave about one-fourth grain, and repeated it in an hour; was sent for the next night to repeat it; can not say whether or not she was a constant user, but think she was. The question is what can you do in such cases? If you do not give it they will send for some one who will.

Dr. Nolder—Was called to see a patient who complained of pains in his bowels; did not suspect morphine habit then. On visiting him afterwards saw his skin was full of needle punctures. He confessed the habit, and wanted to be treated for it. The first time he came for treatment he made an excuse to go to the water closet; was gone so long I followed him, and caught him using a hypodermic; he would insist on continuing its use. I would recommend sulphonal in these cases where there is frenzy on curtailment of the drug; it also acts well in quieting the delirium of typhoid.

---

## Plaster of Paris Dressing for Fracture of the Femur in Children.

*Read at the Meeting of the Central Branch Medical Association, Greenleaf, Kansas, December 4, 1890.*

BY D. W. HUMFREVILLE OF WATERVILLE, KAS.

Doctor Sands of New York, some years ago strongly recommended, for reasons he gave, and results he then obtained, the use of plaster of Paris in recent fractures of the femur, not limiting it to children alone, but for general use, in adults, or in any case of fracture of femur.

Doctor Hamilton, however, after a few trials, would not approve of the treatment of, or the method of Doctor Sands, and being an authority on fractures, the method was abandoned by many surgeons for other modes of treatment, as extension, the bar, weights, or the inclined plane, and other well known methods. All these various methods having proved unsatisfactory in many instances, especially in cases of fracture of femur occurring in children, (in fact many bones requiring rebreaking), or the results being so bad, and so much deformity resulting from shortening

and curvature, that surgeons were again prompted to use plaster of Paris. We well know that one case of deformity, or crippling, as a result of fracture, will injure the reputation of a surgeon for skill, sometimes very seriously; hence, any method giving better results than the old, should be favorably considered, and this we find in the plaster of Paris.

The old method of applying the plaster was to virtually envelop the limb, hence, no examination could be made of it; swelling and other mischief could go on undetected under it, and the plaster became a burden, if not actually injurious, from constricting the limb, or unobserved irritation or pressure.

The good results following the late applications of the plaster are due more to the mode of application than any other cause.

The best method of applying the plaster is the following: The patient having been placed supinely on a firm bed, if possible, with shoulders slightly raised, the skin thoroughly cleansed over the thigh or parts to be covered; extension is now to be made, (this should be made at points distant from the fracture, so that bruising of muscular tissue about fracture will not occur) and the bones properly adjusted.

The limb now being extended and steadied, one or two layers of soft, clean linen, or muslin, are to be placed covering the upper half of the thigh; next, three pieces of cheap, loose textured flannel, which, having been previously prepared by having their substance filled with fine plaster of Paris. In length they should reach from the groin and hip to below the tubercle of tibia, or insertion of ligamenta patella, while their width should be from above middle line of inside of thigh to about half inch below middle line of outside of thigh.

The first layer of piece of flannel is now placed and manipulated in mixture of plaster of Paris and water, which should be slightly warm, as a comfort to a child, and about as thick as gruel, or probably a little thicker. The flannel is now squeezed out lightly, then smoothly and evenly applied over the thigh and knee, the inside edge coming above middle of perpendicular line of inner side of thigh. The upper ends of the layers are permitted temporarily to project above the groin, so that when all are on they can be turned down, forming a rounded border above.

A little of the liquid plaster is now smoothed over the first layer, then the next or second piece of flannel undergoes the same process, being placed directly over the first; a little liquid plaster of Paris is again brushed over, and the last piece is soaked and applied as the others; then a little of the plaster is smoothed over all and permitted to become solid.

The under part of the thigh is next treated in a similar manner, and as the muscles are not so apt to move the fragments in this direction, especially while the child is in a recumbent posture, two layers of flannel may be sufficient, but three should be used in a large child.

The lower or under splint should be large enough to fill the space left after the application of the upper one, less three-fourths of an inch on each side, which should be left free, that the splints may be tightened or loosened according to the amount of swelling, as after the first enlargement the muscles are apt to become smaller for a time. The lower splint should reach from the nates to the fullness of the leg below the knee. When the splints are partly solidified, a bandage can be run from the foot to the knee; next, a many-tailed bandage secures the splints to the thigh.

The advantages this plan offers are these: The muscles are kept in a state of quietude, they being the prime factors in separating the fragments.

2. The fragments are kept in apposition more readily than by any other method, as the splints fit perfectly, and no bony points suffer from an undue amount of pressure, causing sloughing, as has been the case from many old splints.

3. They keep their position.

4. They permit exhalations to pass through while an ingress of air is permitted to reach the skin.

5. The injured part can be readily examined, in whole or in part, at any time without risk of separating the fragments.

6. They are light, cleanly and durable, and

the success that has attended their proper application and use, justifies us in believing that they are peculiarly fitted for splints, as well as furnishing to our patients more comfort during the treatment, and better results in the end.

In connection herewith I will give a brief history, or summary of several cases:

1. H. W., a boy 9 years of age, fell from a barn loft fracturing his thigh; it was treated by one of the conventional methods, the extension bar, but owing to the fixation of the trunk and leg on the bar, and a sinking down of the hips, much deformity resulted. The thigh was again broken and recast in plaster, from which he quickly made a good recovery without deformity or shortening.

2. A child of L. K., and case of Dr. Hardy, with whom I was present, fell from roof to bottom of dugout, breaking femur, which was adjusted and encased with the plaster af Paris splints in the manner above stated. The child soon became comfortable, and made a quick recovery with a thigh apparently perfect—no shortening or deformity.

3. F. B., a 5 year old boy, had his left thigh broken by falling in a ditch with a large farm gate falling with him. Extension was made, and the plaster splints applied as before. After the second day the patient was comfortable, we keeping the splints snug to the parts by the many-tailed bandage. This case also made a perfect recovery, with no resulting deformity or shortening.

The object in giving a few of the cases on which the splints have been used, is to show the good results obtained.

As a summary, I believe we have here a perfect method, keeping the muscles at rest, and adapting itself nicely to the parts; that it is as a real splint, keeping the fragments in position and the bone in proper line; also, in permitting an examination to be made at any period of the treatment. The bone is also prevented from rotating on its axis, and sloughing of parts from undue pressure cannot occur. It is easy of application, inexpensive and adjustable, and can be easily accommodated to enlarging or decreasing size of limb.

Such is the plaster of Paris splints as we believe, and trusting that these thoughts and descriptions may be considered carefully; and if any member has an opportunity, (who is dissatisfied with the old wood and other splints) will give this method a fair trial. I am satisfied that it will yield him better results than any other method.

## Abdominal Section for Uterine Appendages With Appliances.

*Read before the Academy of Medicine and Surgery, at Topeka, Kan.,*

BY M. B. WARD, M. D., OF TOPEKA, KAN.
PROFESSOR OF GYNECOLOGY IN THE KANSAS MEDICAL COLLEGE.

A REPORT OF TWO CASES.

Mr. President and Gentlemen of the Academy of Medicine and Surgery:

My reasons for reporting the following cases are:

1. They are of more than usual interest as regards the morbid growths, (especially the first case) and their rapid and uneventful recovery.

2. That I may, in a slight degree at least, contradict some of the statements from the pens of Drs. Coe and Manley, recently published in the New York *Medical Record*, regarding the unfavorable results of abdominal section.

3. That the attention of our members may be directed to a condition, common indeed, but not usually nor easily recognized, and the great blessings promised to suffering females from this operation in justifiable cases.

Case 1. Mrs. S——, colored, 38 years of age, married and living with her husband, mother of one child six years old; has had two miscarriages. Has a history of gonorrhœa some years ago; for the past two years menstruation irregular and often profuse; for nearly one year she has had a tumor over the pubes which she could easily feel, and supposed she was pregnant; had consulted several physicians, most of them pronouncing her pregnant.

After a thorough examination of her condition on several occasions, I recommended a

prompt removal of the morbid growth, to which she consented.

The operation was done October 16, 1890, in her house, (if house it can be called) assisted by Drs. McClintock and Righter. The preparation of the one and only room was most thorough. The patient was prepared by free purgation with salines, baths of soap and water, and subsequently alcohol. No food of any kind for twenty-four hours before the operation. She was placed in a clean bed twenty-four hours prior to operation and admonished to rest quietly.

These specimens which I now show you were removed from this woman. The smaller one was lying above and to the right of the uterus, and was the mass which had been so plainly felt over the pubes. It was adherent throughout its entire length (about 3 inches) to a coil of intestine, and was in this condition brought out through the incision, and carefully dissected off from the gut. The ragged projections attached to the intestine were trimmed off, and after the danger to bleeding had subsided the coil was dropped into the cavity. The large mass was firmly imbedded in the Douglas' pouch. Carefully, and with no little apprehension (fearing I would rupture the sack) I dislodged the smooth, rounded mass from its bed, and brought it to the abdominal opening, which proved too small to allow its exit. Dr. McClintock enlarged the incision, with my fingers still grasping the tumor, after which there was no trouble to deliver, tie, and cut away.

The cavity was twice thoroughly irrigated and closed without drainage. The incision was closed with five deep and two superficial sutures of silk-worm-gut. Iodoform was dusted over the wound, antiseptic gauze and cotton applied, and the patient snugly bound with flannel bandages.

Nothing occurred at any time to cause the least apprehension. The incision united by primary union. The bowels acted freely and regularly after the first forty-eight hours by the aid of sulphate of magnesia; the urine was voided without the use of the catheter; there was neither bloating nor soreness in the bowels. The bandages had to be tightened at each visit.

The nurse was discharged in sixteen days. In two weeks and a-half she was up about the house, and from that time on has done her housework, including washing, carrying water from a neighbors, &c. In four weeks she walked two and one-half miles in one day. She says she has never felt the least inconvenience from the operation, aside from the confinement and hunger.

The most remarkable feature in connection with the case was the fact that she did not get weak, had no headache, and was not dizzy when she first commenced to walk.

Case 2. Mrs. M——, white, aged 39, married, but not at present living with her husband; mother of two children, the youngest is eight years old; as a girl she was healthy and rugged; her menstruations were usually regular and painless, but nearly always profuse; at times she would bleed until her eyes would become dimmed. Her first confinement left her an invalid; has had four miscarriages; she has always worked very hard. There is an indefinite history of gonorrhœal infection; I cannot, however, assert positively, that gonorrhœa had anything to do with her condition.

"She is now," (copying from my notes made before the operation) "and I judge has been for a long time, a deplorable specimen of female suffering. She cannot ride on the street-car, walk or stand without great suffering. She laughs and cries at the same time, and all the time; her back pains her; she has constant headaches; in short, everything seems to affect her. Examination revealed a lacerated perineum and cervix; the uterus fixed in the pelvis, and behind it appeared a mass which I have diagnosed as prolapsed, enlarged and diseased ovary and tube; I think there is pus. The right side also appears to be enlarged, and is extremely sensitive. Digital examination, however, carefully done causes great suffering. I hope this operation will relieve her suffering and completely restore her health."

The operation was done November 22, 1890, at Christ's Hospital. I was assisted by Drs. McClintock, Mitchell and Righter; there were also present Drs. Sheldon, Green and Peers.

All the details in the preparation of the patient and the technique of the operation were strictly carried out.

The specimens which I now show you were found and removed. The larger one was the left tube and ovary; you will see that the adhesions were terrible; the pedicle where it was ligated is, as you see, an inch in diameter; the ovary is entirely destroyed, and the mass was adhered to the pelvic fascia by as strong a union as was its uterine attachment; the right ovary is also entirely destroyed, but there is still to be seen a mere vestige to mark the region of the ovary. The adhesions were universal and strong, as the specimens plainly show; hemorrhage was uncomfortably free; the uterus was so firmly fastened in its bed that I could not stir it, which made it hardly possible to bring the appendages up through the incision, which was barely two inches in length. The cavity was irrigated with a gallon of water and a drainage inserted.

The incision was sutured with four deep and two superficial sutures of silk-worm-gut. The dressings were the same as described in Case 1. The hemorrhage quickly subsided, and the tube was removed in sixteen hours; the incision healed by primary union; no moisture to stain the gauze dressing was present after the drainage was removed.

The patient has made a pleasant and uneventful recovery up to this date, eleven days after the operation, and says she has never felt any pain below her waist since the operation, when before she did not know what it was to be free from pain, and a constant desire to evacuate her bowels.

I would be pleased to have any and all the members of this society visit the patient in the hospital, and follow up the history of her recovery, that there may be no question raised regarding a biased report. I make this request most heartily, because this is a case, if there ever was one, where we may look for bad results.

[NOTE.—Case No. 2 went to her home well four weeks after the operation.—ED.]

McKINNON reports, in the *Medical World*, a case of strangulated hernia, in which he drew off the gas by using a hypodermic syringe, when the bowel returned spontaneously.

## Complete Adhesion of the Soft Palate to the Pharynx,

WITH AN OPERATION FOR ITS CURE.

*Read before the Missouri Valley Medical Society, at Kansas City, December* 18, 1890.

BY HAL FOSTER, M. D.,
ATTENDING SURGEON OF THROAT AND NOSE DEPARTMENTS OF MISSOURI PACIFIC R. R. AND ALL SAINTS HOSPITALS, KANSAS CITY, MO.

### REPORT OF A CASE.

Mr. President and Gentlemen of Missouri Valley Medical Association:

I will invite your attention briefly to the clinical history only of my patient: Age 40, occupation seaman, a native of France. Applied to me November, 1889, complaining of shortness of breath. He wanted to know if anything could be done to restore his speech. He was able to utter a sound, but he could not turn that sound into words. He had contracted syphilis twenty years previous. He was married, and his wife had miscarried three times; one child was living, and is now twelve years of age, and is apparently in fair health.

This communication was made on paper, as the patient was unable to talk. His nose was entirely gone, down to the nasal bones, so that all that remained was a small opening in the face. The nasal fossæ would fill up with large green crusts, which he dislodged with a hairpin every morning and evening. The stench from these crusts was exceedingly offensive. I took out two, which were fully two and a half inches in length and shell-like in form. The patient's mouth was so closed up by syphilitic adhesions that I could pass in my two fingers only, with great difficulty, by stretching the mouth to its utmost capacity.

A complete laryngoscopic view of the throat at this stage was impossible. The first operation I undertook was enlargement of the mouth, which was done by means of a knife; afterwards little wooden stretchers, or gags, were inserted, to prevent the wounded surfaces from growing together again. After this was accomplished I found that the uvula and the lower part of the soft palate were en-

tirely destroyed, and the remaining part of the palate was firmly adherent to the pharynx, so that the upper pharynx was completely separated from the lower pharynx.

The complete occlusion of the two pharynges is extremely rare. I have met with it in only three cases. It is by no means rare in tertiary syphilis of the throat to find a partial adhesion of the parts; but it is extremely rare to find a complete adhesion. Often a small opening can be discovered, sometimes only large enough to admit a small current of air. In this case I covered the lower pharynx with iodoform, and filled the nasal fossæ with water. My iodoform was not moistened. I now determined to liberate the palate from the pharynx, so that I could give my patient nasal breathing, and also give the nasal cavity an outlet into the throat. I first passed a silver probe down through the nose to the pharynx, and with a tenotomy knife cut where the palate bellied.

After I had thoroughly separated the palate from its attachment, with no little difficulty, the parts were sprayed with a solution of tannin. No anæsthetic of any kind was used. I now began to pass the largest sound I could obtain through the opening into the upper pharynx. I afterward had a sound made of the following description:

The body of the instrument was about two inches in length and was blunt, pointed at the end, and gradually widened as it reached the base; it was somewhat similar to a triangle in shape. The base was an inch and a-half in width. To the broad end of the instrument was attached a long handle, so that it could be manipulated in the throat.

I found that with this instrument I could keep the opening the required size, and prevent it from closing. Had the wound not been treated with sounds after cutting, the opening would have filled up in a very short time. This is a peculiar characteristic of syphilitic tissue, where we seek to enlarge an opening, whether it be in the pharynx or nasal fossæ.

In a case of nasal stenosis, now under observation, I have seen the parts close completely after opening the nasal canal three times, every time giving the patient complete breathing space, taking out at each operation a large piece of cartilage at the point of union. In a short time the parts were firmly adherent again.

The parts in this operation healed nicely, and within four days absolutely no pain was felt from the passage of the instrument. An examination of the larynx showed complete paralysis of the abductors of the vocal cords, and the whole mucous membrane lining the larynx was in a state of hyperæmia; this accounted for his loss of voice.

At the beginning of my operations I had placed my patient under iodide of potassium, but was compelled to give him ninety grains three times a day, before I could produce any effect. I do not consider this an unusually large dose in cases of tertiary syphilis of the throat or nose, and often give larger doses, and maintain them during a longer time. This was given in Vichy water; his stomach stood it nicely, and I kept this amount of iodide up for two weeks, when the amount was gradually reduced. Later I gave him only tonic doses.

Within a month and a-half from the time of the first operation on the mouth, the patient had entirely regained his voice, and had increased something like fifteen pounds in weight. His voice was now quite clear and strong.

Last August, while attending the Manhattan Throat Hospital in New York, I had Tiemann & Co. to make him an artificial nose, which supplied his missing member very well.

I gave him one of the sounds above described, and told him to use it once or twice a week for a year. I often hear from him, and he reports the breathing through his artificial member excellent, and his voice good.

DR. LANDRECZKY, of Jerusalem, claims to have cured a case of leprosy. He relied upon a tonic regimen and a variety of baths of which hot water was the constant feature.—*Medical Mirror.*

PINE tar pigments and the cyanides of iron, potassium, zinc, gold and silver, are the latest specifics in tuberculosis.—*Progress.*

DR. B. S. SNYDER of Pittsburg, Kansas, was a Capital visitor in December.

## Abdominal Surgery.

### REPORT OF EIGHT RECENT CASES.

BY J. C. M'CLINTOCK, M. D., TOPEKA,
PROF. OF SURGERY IN THE KANSAS MEDICAL COLLEGE.

So many causes combine to make abdominal surgery successful that I cannot do better than to classify them as follows; first, as to the operator himself; second, as to the surroundings; third, as to the patient.

As to the operator himself:

A.—He should be a skillful, practical, general surgeon, for it is seldom that an obstetrician is properly qualified for this class of work, although many do drift into this field.

B.—A great amount of time is required for the proper and necessary study and appreciation of the different injuries and diseases of the abdominal and pelvic organs, to place the operator in a position to cope with the various conditions in this class of diseases.

C.—Experience is an important element of success and one should not attempt the operations—except in an emergency—without proper training under a skillful operator, thereby learning the technique and details which contribute to successful operations.

D.—The operator must be absolutely clean, even to the verge of crankyism, both in himself and in all the details of his work.

As to the surroundings:

If the operation be done in a hospital it should be in a private room and not in a general operating room. It can, however, be done very well, in many cases better, in private houses. Much more preparation is needed in a private dwelling than in a hospital where the rules are that every room is cleaned after each case. Whatever room is chosen should have a good light, a north light is preferred so as to avoid the direct sunlight. In any case that room should be taken which would give the proper amount of llght, even though white muslin should need to be tacked over the window to exclude the direct rays of the sun.

Everything in the room should be removed except the operating and instrument tables. The walls, ceiling, floor and wood-work should all be washed a day or two prior to the operation. The table should be covered with blankets and sheets fresh from the laundry, and the instrument table covered with clean towels. Strict cleanliness should be enforced during the operation and if by any chance an instrument should be dropped, that instrument is to be excluded from further use during the operation.

As to the patient:

The operation should be performed as quickly as possible after a decision is made and consent to operation is obtained. The patient should have a restricted diet for several days prior to the operation, consisting principally of liquid foods, interdicting all vegetables—no food should be given for twelve or twenty-four hours immediately preceding the operation. The bowels should be thoroughly evacuated by daily administrations of Epsom salts, when at time of operation the bowels will be found empty, lying like ribbons out of the way of the operator.

Attention should be paid to strict personal cleanliness of patient, requiring baths with hot water, soap and brush, paying particular attention to umbilicus and pubes. Vaginal douches and a rectal enema should be given on the morning of the operation.

During the operation the patient rests on clean blankets covered with clean sheets, a woolen sack with sleeves is worn next the body, with the chest and lower extremities enveloped in woolen blankets. Clean towels covered with gauze, should be spread about the site of operation, to catch instruments should they fall.

A final washing of the abdomen should now be made, finishing with ether, alcohol and lastly with water.

As to the articles needed in the operation and their preparation I would refer the reader to page 127, of Vol. 1, of the KANSAS MEDICAL JOURNAL, and need only say in this connection, that the instruments should be few in number, simple and smooth in construction and preferably of metal. All articles needed should have been boiled before the operation.

Silk is the best material for ligatures, its only disadvantage being the great length of time required for its absorption. Silk worm

gut is an admirable material for the abdominal suture, but it should be tied with a reef knot, and it is safer with a third knot thrown on before clipping the ends; it does not tie well in a surgeon's knot. If the abdomen needs drainage as many of the cases will, use a glass drainage tube six or seven inches in length, the upper extremity shaped like a test tube, the lower extremity open, but without side perforations, except they be about the lower end of the tube; this can readily be emptied at any time with the hard rubber uterine syringe, with long pipe.

Pure boiled water free from specks or sediment is all that should ever enter the abdominal cavity. No antiseptics should under any circumstances enter the abdomen during these operations.

If pus should be met with, it should be washed out thoroughly and drainage provided.

THE OPERATION.

First, the incision should be as short as possible for the operation, many of the operations can be done through an inch and one-half or a two-inch incision. In the small incision, less shock is induced, and there is less liability of ventral hernia following the operation, but one should not restrict himself to a small incision if the work can be better done through a large incision. An estimate of the thickness of the superficial fascia is made by picking up the tissues between the thumb and finger; and the first incision will carry one through the superficial structures, when the muscular or tendonous layer should be divided, exposing the subperitoneal fat; this is separated, the peritoneum is caught up and divided between two pairs of hæmostatic forceps after all hemorrhage is checked.

The following eight cases of abdominal section have been done in my practice within the last two months, with seven remarkably good recoveries and one death. One operation was done for a cyst of the broad ligament, three for fibroid tumors of the uterus, two of ovariotomy, one Tait's operation for reflex symptoms (hyperæsthesia) referred to the spinal nerves and cord, and one laparotomy for perforative appendicitis.

Case 1. In the first case, I operated on Mrs. S., at Christ's Hospital, in the city of Topeka, in October, 1890. After the usual elaborate preliminary precautions had been taken, I made an incision two and one-half inches in length through the linea alba, and on passing the fingers into the abdominal cavity I found apparently normal tubes and ovaries. The uterus was displaced to the right and a cyst on the left raised the broad ligament into a tumor the size of one's head. There was no pedicle, but the entire floor of the pelvis on this side seemed to be raised above the brim. The peritoneum over the tumor was opened and a prolonged effort made to enucleate the cyst wall from the broad ligament. This was found impossible and the patient turned on her side, the cyst opened, drained and washed out. I then made an effort to separate the cyst wall which was impossible. The edges of the perforation were then brought up and stitched into the lower angle of the abdominal wound. A drainage tube was inserted into the cyst and as some of the cyst contents had escaped into the peritoneal cavity, another tube was passed into this cavity, after it had been well irrigated with clean warm water. This second tube was removed nine hours after the operation, but the first was allowed to remain in the cyst for two days, when the glass tube was replaced by a soft rubber one and the cyst kept open for more than two weeks until it was seen that the cyst had closed and no secretion would be expected to take place into it. It has shown no sign of refilling up to the present time, and no more than two drachms have been drained since the operation, and that within the first twenty-four hours.

The patient made an uneventful recovery, the temperature not rising to 100 degrees at any time after the operation. She left her room three weeks after the operation and walks or rides about now as she pleases.

Case 2. In the second case the operation was done for an interstitial uterine fibroma. The growth was apparently as large as a uterus six months advanced in pregnancy. The tumor had been noticed by the patient for about a year, and part of that time she had thought herself pregnant, and had made preparations accordingly.

On examination a hard nodular tumor was

found rising above the umbilicus, movable in all directions, and carrying with it as one mass, the uterus, no pedicle being found.

The operation was done in a very clean and sanitary room in the State Insane Asylum at Topeka. Very careful and elaborate preparations were made and the operation was done through a short incision in the linea alba midway between the umbilicus and pubes.

The growth was found to spring from and be a part of the anterior wall of the uterus. The tubes and ovaries were consequently found on the posterior surface of the tumor, and it seemed that it would be impossible to remove them and that a hysterectomy would be required. However, after the abdominal incision had been slightly enlarged and the tumor rotated first to the right and then in the opposite direction, so that the left and right tubes and ovaries might in succession be removed, which was accomplished with much difficulty, the tubes and ovaries were taken off close to their uterine attachments.

Tait says in effect, "That the removal of the tubes and ovaries is all that is needed for the cure of these cases. That it will cure 95 per cent. of them, and that the cases in which it is unsuitable, or the least promising, is in the soft myomatous variety."

Why these growths disappear after the operation is perhaps explained by the fact that after the menopause these growths will, many of them, disappear almost entirely along with the general atrophy of the internal generative organs, and to this we have further diminished the blood supply by including in the ligature the ovarian artery, or almost all of its branches.

These growths are of so low a vitality that they cannot withstand the effect of so great an interference with their nutrition, but degenerate and disappear by absorption.

Suppose though, that this case had not shown these signs of a probable cure, and the growth had gone on increasing in size, the patient has not been exposed to a great risk, and no adhesions have formed as a result of the operation, consequently, she is in as good a condition for hysterectomy as at the time of the first operation.

The tubes and ovaries were normal, but the anterior wall of the uterus was apparently gone and its place supplied by the tissues of the new growth.

No adhesions were encountered at any place, and as no hemorrhage had occurred and the peritoneum was not soiled, there was no need for a drainage tube, consequently the abdominal wall, including all the tissues, was closed with silk-worm gut sutures. The external surface was dusted with iodoform and an occlusive dressing applied with a binder.

The patient suffered for some hours with thirst but in no other way. She made a rapid and remarkably good recovery, was up and walking about as soon as her medical attendant, Dr. M. R. Mitchell would permit, and at the end of five weeks went away on a visit. I am now informed that the growth shows decided signs of disappearance; has become smaller and softer.

Case 3. There were fouud very small subserous fibroid tumors, and a larger interstitial growth in the anterior wall. In this case the operation was done to stop the exhausting hemorrhage which the patient found she could not endure. The tubes and ovaries were removed without any difficulty. The patient made a recovery without any ill effect of any kind except that she suffered pain on the first night following the operation.

This patient also made a rapid recovery and a report of the details of the case from day to day would be uninteresting as nothing of any importance occurred in the progress of the case.

Case 4. Was operated on for an interstitial fibroid of the uterus. Tait's operation was chosen, removing a cystic ovary with the tube and a cyst of the broad ligament. A prolonged search by Dr. M. B. Ward and myself for the other ovary and tube was made, but none was found if present. The tumor was carefully examined both by sight and touch, but no place could be discovered wherein the ovary could be enclosed or spread out upon it. No adhesions were in the way to offer any obstacle to its discovery: we therefore reluctantly called it a case of congenital absence of one ovary: though this is so rare a doubt will for some time remain. The next day the patient passed her urine without the use of a

catheter, and on the following day her bowels were moved by Epsom salts.

A continued normal pulse and temperature, and freedom from abdominal soreness and tenderness, makes up her after history to the present time. On the third day after the operation, the patient said she was able to do a good day's work.

Case 5. Was operated on for multilocular ovarian tumor in a woman 55 years of age in Dodge City, Kansas. The patient was too weak to be brought from her home to Topeka for the operation. She was very much emaciated, and it was questionable whether an operation was justifiable in so advanced a stage of the disease.

An incision four or five inches in length was made below the umbilicus. Two semi-solid cystic tumors were exposed, apparently made up of small cysts, which proved under microscopical examination to be a cysto-sarcoma. The left tumor was first removed, and was found adherent to its fellow over a large extent of its surface, and was moreover adherent to the pelvic walls and to the rectum. A long and tedious dissection was necessary before it could be brought up and delivered after breaking down the small cysts and evacuating their contents. A very large stump was left, which was compressed and brought down to a reasonable size with heavy temporary ligatures, after which the pedicle was secured by a heavy double ligature by transfixion.

A great deal of blood was lost, and the second tumor was still bleeding on the surface, which had been separated, and did not cease until a temporary ligature was thrown about its pedicle. The second tumor was found adherent to the colon, to the stomach, and to the small intestines.

The separation of these tumors was very difficult and tedious. At one place so firm was the connection, that a portion of the cyst wall was necessarily left on the surface of the intestine. A heavy silk ligature, by transfixion, was used over the smaller pedicle of this tumor, and the hemorrhage almost entirely ceased, although some blood still welled up from the pelvis after the pedicles were brought back.

The patient was now in a very critical condition, and it was questionable whether the abdominal wound could be closed before the death of the patient, which was momentarily expected.

A drainage tube was passed down into the Douglas cul-de-sac, and the parietes closed with silk-worm gut sutures; the patient put back into bed, and external heat applied. The patient rallied within ten minutes, and her pulse came down from 160 to 120, and in a few hours fell to 90, and the next morning it was almost normal as was the temperature, and at noon of the day following the operation I left the patient, feeling that she had good prospects of recovery. The hemorrhage had ceased during the night and the drainage tube was removed. Union by first intention of the wound occurred.

Ten days later I received a letter from her attending physician saying that the patient was up, walking about, and with the best of prospects.

On the fourteenth day I was called to see her, when I found on examination a collection of fluid which I thought to be purulent, pressing down into the Douglas pouch. Into this I made an incision, and evacuated quite a large quantity of clear, sweet-smelling serum. A drainage tube was inserted, and the vagina washed out regularly for some time thereafter.

Twelve days later, or on the twenty-sixth day after the operation the patient died of exhaustion, as reported by the attending physician, Dr. Rose.

Case 6. A married lady five years ago had a miscarriage at four months, followed by peritonitis, which confined her to her bed eleven months; she has suffered ever since with recurring attacks of peritonitis, and has developed epilepsy, the attacks coming on from four, to nine or ten times each day, applied to me for treatment, and on examination I found the pelvis and lower part of the abdomen filled with inflammatory masses, and apparently agglutinated intestines; the region of the ovaries filled with masses which gave an indistinct sense of fluctuation. From the effect of the epilepsy she had become very irritable.

I had her removed to Christ's Hospital, opened the abdomen, separated the adhesions,

and found two small ovarian tumors which were adherent throughout their entire extent to the surfaces with which they were in contact; these I separated, and after draining the cysts delivered them; first the right, which was the size of a cocoanut, then the left, a smaller one. Quite a free hemorrhage followed from the points of adhesion, which lasted for forty-eight hours, during which time a drainage tube was kept in place, which was evacuated every half hour; and as the hemorrhage showed no sign of decreasing in quantity, the nurse was instructed to exhaust the tube every ten minutes, thereby drying out the peritoneum, which expedient proved successful in arresting the hemorrhage, and when nothing but serum could be withdrawn the tube was removed.

The patient was at first very intractable, would throw off the covers, get up, fight with two or three nurses, and it was necessary to treat her as an insane person, tying her to the bed, each extremity being tied to a bed-post or rail, and her body also tied down. She took cold and had a bronchitis which lasted about a week, but aside from these had no bad symptoms. She is able to walk about, ride out, and has made a journey to another city to visit friends; feels perfectly happy; is relieved of all her mental symptoms, except that she has had two slight convulsions in the seven weeks since the operation.

Case 7. This patient was suffering most intensely from hyperæsthesia, which was found to be dependent upon ovarian disease, and it could be partially relieved by raising the prolapsed ovaries, although they could not be raised to any great extent as they were bound down by inflammatory adhesions.

Dr. W. S. Lindsay was called and assisted in making the diagnosis and ordering the treatment, which was carried out faithfully for a month with only transient relief, and a resort to extirpation of the ovaries was deemed the only possible method of relief for the sufferer; accordingly she was sent to her home in Manhattan, placed under the charge of her family physician, Dr. H. S. Roberts, who with Drs. Lyman and Righter, assisted in the operation, which was done on November 5.

The adhesive bands were easily broken up and the ovaries and tubes removed. One of the ovaries was undergoing cystic degeneration. No complication arose in the operation or in the after treatment of the case, and the patient promptly recovered from the operation. When I visited her one month after the operation I found her walking about, and learned that she had walked out in the yard, although she was using extreme care in limiting her exercise.

A recent letter from Dr. Roberts informs me that she is much improved from hyperæsthesia, and I look for a complete recovery.

Case 8. The last case was for a perforation of the appendix vermiformis. The patient being a daughter of one of the most prominent physicians of Topeka, sixteen years of age, very robust and healthy, was attacked with severe pain.

The case was diagnosed and treated by Dr. S. G. Stewart of this city; and after determining the presence of pus on the tenth day, he called me to make the operation, which was done immediately. An oblique incision one inch and a-half in length was made in the right illiac region, over the most prominent part of the swelling. This opened directly into the free peritoneal cavity, and exposed a tumor made up of coils of intestine matted together; to separate them and allow pus to escape into the free peritoneal cavity, which was now shut off by this limiting wall, was thought to be not good practice, and the steel handle of the knife was passed in, and pointed out a place where the tumor could be opened without opening into the peritoneal cavity; accordingly the first incision was closed by three rows of sutures—the first included the peritoneum, the second the muscles and fascia, and superficial stitches above these. A second incision was then made in the selected site, near Poupart's ligament, its outer extremity. The incision was carried directly into the abscess cavity, and a large quantity of very fetid pus was evacuated, and the kernel of a peanut was brought out with the fingers. A very thorough and careful examination was made by Dr. Stewart and myself, but we could find neither the perforation nor the vermiform appendage.

As it was not thought best to break down

the abscess wall, but rather to depend upon a secondary operation, if it became necessary, a thorough irrigation was employed, a glass drainage tube inserted, and the two wounds, although close together were dressed separately, as well as possible. Some pus, and once or twice a show of fæces appeared through the drainage tube, and the first incision became infected to the extent of having a development of a small subcutaneous abscess. The second incision was kept open and gradually healed from the bottom out, until now it has closed entirely.

The patient made a slow but steady recovery; the high temperature dropped almost to normal soon after the operation, and so remained. Great credit is due Dr. Stewart for his care and attention during the course of the disease.

ECTOPIC GESTATION.—Dr. Reed's conclusions are:

1. The only proper treatment of ectopic gestation is that by abdominal section.

2. The operation should be done in cases before rupture so soon as the condition can be presumptively diagnosed.

3. The operation should be done in cases after rupture so soon as the evidences of internal hæmorrhage become apparent.

4. In cases in which the viability has already been reached without rupture, pregnancy should be allowed to advance to term before operation, but only under the closest possible vigilance.

5. In all cases the appendages from both sides should be removed providing the condition of the patient will justify the extension of the operation

PREVENTION OF "BLACK EYES."—Practitioners who number many football players or members of the Pelican Club, among their patients may be glad to know of the following remedy, which an American contemporary vaunts as the "sovrans't thing on earth" for bruises of all kinds. The preparation consists of the tincture or a strong infusion of capsicum annuum, with an equal bulk of gum arabic, to which a few drops of glycerine are added. This should be painted over the injured surface with a camel's-hair pencil and allowed to dry a second or third coating being applied as soon as the first one is dry. If this is done as soon as the injury is inflicted, we are assured that the blackening of the bruised tissue will "invaribly" be prevented. The same remedy is recommended as having "no equal" in rheumatic stiff neck.—*Brttish Med. Jour.*

THE "Pulitzer building" the Home of the New York *World*, is the largest newspaper building in existence, has just been completed and occupied. It was erected by the pennies from the sale of the *World*. We acknowledge the receipt of a souvenir.

## BOOK REVIEWS.

"OINTMENTS AND OLEATES"—Especially in skin disease. By John V. Shoemaker, A. M., M. D., Professor of Materia Medica, Pharmocology, Therapeutics, and Clinical Professor of the Diseases of the Skin in the Medico-Chirurgical College of Philadelphia, &c. Second edition, revised and enlarged 12 mo. cloth. Publisher, F. A. Davis, Philadelphia, 1890.

The examination of the volume was a source of great pleasure. The subject matter is of particular current interest, and it is treated in such a practical manner, by so experienced an authority, that physicians and pharmacists alike may profitably accept the volume as standard in practice. The revised edition is completed and enlarged up to date, fully covering the subject of officinal preparations used not only in the United States, but also of the various European countries.

The author concisely concludes his preface as follows:

"The reader may thus obtain a conspectus of the whole subject of inunction as it exists to-day in the civilized world. In all cases the mode of preparation is given, and the therapeutical applications described seriatim, in so far as may be done without needless repetition."

We have nothing to add to this, except to unqualifiedly recommend the book as an actual necessity for the alert student and pharmacist.

J. W. D.

# Kansas Medical Journal.

PUBLISHED MONTHLY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE:

Per Annum, in advance.....$2 00
Single Copies.....25 Cents.

Subscription may begin at any time. The safest mode of remitttance is by bank check or postal money order drawn to the order of the undersigned. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in REGISTERED LETTER. Address

Kansas Medical Journal,
723 Kansas Avenue.

Editor-in-Chief:
J. E. MINNEY, A. M., M. D., Topeka, Kas.
Assistants:
W. L. SCHENCK, M. D., Osage City, Kas.
S.G. STEWART, M. D., Topeka Kansas.
Associate Editors:
W. D. BIDWELL, M. D., Leavenworth.
W. A. PHILLIPS, M. D., Salina.
W. F. SAWHILL, M. D., Concordia.
T. W. PEERS, M. D., Topeka.

TOPEKA, KANSAS, JANUARY, 1891.


## Christmas Greeting.

ON this natal day of Him who healed the sick, gave sight to the blind and made the lame to walk, we extend to all our readers the *compliments of the season* and wish them A MERRY CHRISTMAS AND A HAPPY NEW YEAR.

As the Master recognized no nobler, grander work than making day by day the life that now is stronger and better, and as all life of which we may take cognizance is made stronger and better through the instrumentality of that life which is your care, no nobler work than yours has fallen to the lot of man.

You may well be merry over the achievements of the past, and happy over an ever expanding future.

Though this annual mile-stone marks no notable progress in any special department of medicine, there has been an important advance along the whole line, honorable to the profession and full of promise. None recognize so well the failure of the old two-course system of college study,as those who gave and received it, though on general principles all may see the folly of requiring the student to attend lectures on practice, obstetrics and surgery, when he has just commenced materia medica, physiology and anatomy. It is like teaching simple addition and conic sections, or the Greek alphabet and Greek translation at the same time.

At the National Association of Medical Colleges, held during the meeting of the American Medical Association, it was resolved with great unaniminty to require as a prerequisite to matriculation at least an academic education and as a preequisite to graduation a graded course of three full years. In many States this is now becoming a necessity as most State Boards of Health whom their legislatures have given power to protect the people against ignorant pretenders in medicine, have decided that in the near future diplomas from schools requiring less will not be accepted.

During the past year there has been a noticeable disposition on the part of the profession to guard against what is its desire to overcome, pathological expressions often prove a source of weakness—a disposition to jump at conclusions not warranted by the premises. Thus three years ago quite a number of good men were willing to believe that a little sulphureted hydrogen injected into the rectum would destroy the tubercle baccillus and so remove the tubercle of phthisis. To day when a greater than Burgeon comes forward with a more rational method of cure, injecting into the circulation some agent that will destroy the immature differentiation of tuberculosis without injuring other groups of tissue, these men ask us to wait until time has furnished proof. These simply wait, while some of the microphobists, when they learned the great advocate of the germ theory, had found a remedy for consumption based upon the destruction of the neoplasm and not of the baccilli, turn aside with disgust.

There is still a disposition upon the part of some medical writers to gush over new remedies with wonderful names. There may be method in their madness. Whether their recommendations are for a consideration or otherwise time alone can fix their value, and only a few of the numberless "new remedies" that flood the market will bear its test.

During the year the antiseptic treatment of

wounds has changed from germicidal intent to cleanliness and the exclusion of all contaminating matter. In Kansas the number of points where variola has appeared shows sad neglect of its known prophylaxis, while in every instance its speedy arrest has added new laurels to the crown of the immortal Jenner.

Thanking all our readers and contributors for their cordial support during the year that draws to its close we pledge an earnest effort to make the KANSAS MEDICAL JOURNAL worthy their continued confidence and support.

## Alkalies in Acidity.

In our clippings we have referred to alkalies in acidity. The normal secretion of the stomach is acid. In health, when it is most abundant, immediately after a full meal, the stomach feels "as happy as a clam at high tide;" when it suffers it is not because of the acidity of its secretions, but because there is abnormal sensitiveness of the œsophageal and gastric plexus.

Acidity is sometimes considered a diseased condition consequent upon excessive secretion of lactic acid, excessive gastric activity, that is excess of vital action. Such a view means faulty diagnosis and faulty treatment.

If pain and acid eructations occur soon after meals, they do not arise from an excessive secretion of gastric juice, but from hyperæsthesia of the gastric nerves. When occurring more remotely they are evidence of a deficiency of gastric solvents and retarded digestion. Albumen will dissolve more quickly in a concentrated than in a dilute solution of pepsin, and pepsin neutralized with an alkali loses its solvent power. When there is a deficiency in the quantity of pepsin instead of digestion and the formation of chyle, food may undergo decomposition; and if the vital act is delayed the character of the organic mixture, its warmth and moisture, makes the chemical action prompt, and the formation of lactic and fatty acids abundant. Unlike the secretion of gastric juice the formation of these acids is proof of gastric debility.

Gastric or hydrochloric acid, taken in a little water immediately before each meal, will prevent this acidity on a physiological basis; partly by their action on the food, but chiefly by neutralizing the alkaline saliva and dissolving the gastric mucus that have accumulated in the stomach, thus permitting the excretion of its pepsin.

When the acidity is the result of chemical, and not biological action, and occurs after digestion should have been completed, or from the secretion of lactic acid after food should have been digested, alkalies are advantageous. When a meal has been digested the gastric glands rest, and the œsophagus and stomach are bathed with the alkaline salivary secretions. Intelligent practitioners at alkaline springs, all recommend the water to be drank after the stomach has had time to digest its food.

Whether the unpleasant sensations following the ingestion of food are due to hyperæsthesia, or to faulty excretion of pepsin, alkalies must be used with wise discretion, especially carbonated alkalies; for while they may give temporary relief by interference with the digestion of albuminoids, they may cause permanent injury.

With nervous patients, and those depressed by anxious care—and the world is full of them—hydrocyanic acid, in conjunction with such general measures as tend to health, will often give permanent relief.

But the scientific treatment of this form of indigestion lies not in adjuvants, not in anæsthetizing over sensitive nerves, not in neutralizing acids, but in renewing the vitality of the organs of digestion. The bitter tonics, as gentian, strychnine and quinine, with iron and properly regulated diet and exercise, are the safe and sure methods of cure. S.

## To the Members of the Kansas Medical Society.

Those who have attended the meeting of the State Society the past few years, have noticed advancement in the character of exercises, and the interest manifested in the reading and discussion of papers. It is to be expected that the Kansas Medical Society should keep pace with other institutions of the state, and it is gratifying to note that the last meet-

ing at Salina was a marked improvement on any previous meeting.

While this is true, there are still defects in our plan of proceedings. The transactions of a state medical association should, in a great measure, reflect the thought and progress in medicine, of the state, for the period represented. To do this with credit much more time should be devoted to the work, not only in preparation but at the meetings.

When we consider the number of good papers presented now, and the increase likely to accrue in the near future, it is apparent that time for full discussion cannot be had in the one and a-half to two days' sessions, now the custom. We are all benefited more by discussion, including as it does the practical experiences, failures and minor points so frequently omitted from a paper, than by hearing the hurried reading necessary to our expeditious custom.

The meeting next May will be in Wichita, and from the indications of the various sections, there will be more valuable matter than ever before presented. It will be the aim to have a four days' session, and with the cooperation of members we can have a most important and satisfactory meeting.

I will be glad to correspond with any who may have papers, cases or specimens to offer, who may not be reached by the sections.

Secretaries of the sections are, viz.:

Surgery—L. H. Munn, Topeka.

Medicine—C. Klippel, Hutchinson.

Obstetrics and Gynecology—A. Fabrique, Wichita.

Ophthalmology and Otology—G. A. Wall, Topeka.

W. S. LINDSAY, Secretary,
621 Kansas ave., Topeka, Kan.

## Quinine--Its Mode of Administration.

While elegant preparations are in demand it is always poor economy, as well as bad therapy, to disguise taste at the expense of utility. The vehicle should not interfere with the prompt and full action of the agent.

Quinine is given largely in pills and capsules. They cheat the gustatory nerves by smuggling it into the stomach. While the deglutary apparatus of some patients is not equal to this mode of administration, when it reaches the stomach, so far from being digested it often passes through the alimentary canal unchanged. When given in this way it should be followed by an appropriate acid drink—citric, hydro-bromic, or hydrochloric, will generally cover the indication.

Quinine is often mixed with an alkali, as in the *tastless quinine*. In this form it is rendered less soluble, but if followed, as above, by an acid, the objection is removed, and the stomach is not infrequently benefited by the carbonic acid gas that is set free. When combined with some other bitter, with some aromatic added, its intensity is modified. It is thus that extract of taraxicum and cascara cordial improve its taste; and not infrequently its effect by stimulating hepotic action and keeping the bowels soluble.

Glycyrrhizin, an insoluble glucoside makes quinine insoluble, and so liquorice has long been a favorite medium for its administration. An alkaline mixture taken immediately after will restore its solubility. It may be mixed with the fluid extract of liquorice in the prescription, or with the aromatic elixir rubbed up with it when taken, or with one-fourth its weight of ammonium glycyrrhizate.

With many yerba santa is a favorite menstrum. It covers the taste in much the same way as the glycyrrhiza, and should be followed by a mild alkaline mixture. The aromatic syrup makes a well-nigh perfect medicine.

As all the agents that conceal the taste of quinine do so by rendering it insoluble, if we want its full and prompt action, it should be followed by some agent that will restore its solubility.

When the bitter taste is not objectionable its efficiency may be increased, and cinchonism be prevented by giving it in hydrobromic acid.

When a prompt and powerful effect is desired it may be given hypodermically.

When the stomach will not bear it it can be given in suppositories or enemas.

Inunctions, especially with the oleate of quinine, often produce prompt results, especially with children.

## LITTLE THINGS.

SEND your JOURNALS in and have them bound.

DR. L. L. UHLS spent a part of December in Chicago.

A GLASS and metal operating table has been invented.

THE Kansas Medical College adjourned over the holidays.

THE Golden Belt District Medical Society is coming to the front nicely.

DR. POINDEXTER, of Fort Scott, has been sojourning in the city a few days.

IN your holiday remembrances don't forget the JOURNAL. Send in your subscription.

ATTEND the Eastern Kansas District Medical Society: It is only second in importance to the State society.

DR. E. B. SHAW has gone back to his old home, Osage City, Kansas, from Kansas City, Missouri. We welcome him back to Kansas again. "Home, sweet home."

DR. W. E. MCVEY has quit the general practice of medicine and will confine his practice to laryngology and rhinology. Office rooms 4 and 5, 723 Kansas avenue.

DR. W. R. VAN TUYL, of Fairmount, had a severe attack of acute articular rheumatism, and no longer wonders that insurance companies ask so many questions about it.

DR. G. O. MORGRIDGE, is recovering from an attack of blood poisoning incurred by a prick of a pin on the finger in dressing a wound.

DR. W. D. BIDWELL, the Leavenworth end of the JOURNAL spent Christmas in Topeka. The doctor expressed himself as being very much happified with his holiday in Topeka.

DR. J. H. VAN EMAN, of Kansas City, has been very sick for over six weeks. His attending physicians have studied his case very carefully, but are not satisfied as to the diagnosis.

DR. C. E. NELSON, of Kensington, Kansas, is taking a special course in Ophthalmology and Otology, in the office of Drs. Minney & Magee, and Dissection in the Kansas Medical College.

To arrest acute catarrh:

R. Wormword tinct. verat
Tinct aconite aaʒi.
Tinct. belladonna ʒij. M.
Sig. Two drops every hour.

DR. J. S. BILLINGSLEY, of the firm of Arthbuthnot & Billingsley, of Belleville, Kansas, paid us a very pleasant call last month—swapping a few jokes and exchanging experiences. Call again doctor.

DR. E. B. ALLEN of Wichita, ex-secretary of State, called on us on his way back from the Chicago Polyclinic, where he has been taking a special course, and will resume the practice of medicine at Wichita.

TOTAL vaginal extirpation of the uterus in all cases of cancer of that organ, whenever the condition permitted was the unanimous opinion of the section for gynecology at the Tenth International Medical Congress.

DR. C. R. CARPENTER, of Leavenworth, has devised a very ingenious substitute for the old metal style of the Toynbee artificial ear drum, which he demonstrated at a recent meeting of the Leavenworth Medical Society.

THE Indian scare is giving some young medical officers their first experience in the field, and they sigh for the flesh-pots of medical school as they turn out of their tents with the thermometer 19° below zero, and eat icicles of coffee.

DR. J. A. LANE, of Leavenworth, was severely injured December 8, the axle to his buggy breaking while he was driving rapidly down hill. One rib was broken, both knees were badly bruised, and the doctor was severely shaken up.

THE death of Jedediah Baxter, M. D., leaves the office of Surgen-General vacant, and the many friends of Dr. C. C. Page, Medical Director of the Department of the Missouri, lately stationed at Fort Leavenworth, hope that he will receive the appointment.

For bronchitis:

R. Ammon. carbonate ʒij.
Syr. pruni virg.
Tinct. opii camph. } aaʒi
Syr. tolu
Aquæ Gaultheria qs. ad. ʒjv.
M. S. A teaspoonful every three hours.

IN USING hydrochlorate of cocaine in connection with silver nitrate, the irritation caused thereby is due to the reaction taking place between the two. The hydrochloric acid of the cocaine hydrochlorate being simply in combination with the alkaloid thus, $C_{17}$ $H_2$, $NO_4$ HO, is easily separated, and unites with the silver nitrate to form silver chloride and nitric acid thus, $Ag\,NO_3 \nearrow H\dot{C}l = Ag\dot{C}l \nearrow H\dot{N}O_3$, and the nitric acid so formed is the irritant element of the combination.

THE *Druggists Circular* gives the particulars of a death from "nitrous oxide gas." A man aged twenty-four, was examined and found to be free from heart and lung disease; the gas was administered at his request, as he wished to have a tooth drawn. No sooner was the tooth extracted than the man gave a gasp and fell over in the chair. He was placed on the floor, and all the usual means used to resuscitate him but without avail.

. ACUTE articular rheumatism has been successfully treated with full doses of phenacetine, commencing with 15 grains every 3 hours, gradually increasing the amount each day until the joints become movable, when after three days it may be gradually increased, but should be continued in 15 grain doses 3 times a day for a week after the pain is relieved.

DR. LANPHEAR, editor of the *Medical Index*, says that "Emmett's operation for lacerations of the cervix will soon be a thing of the past; that subinvolution is the cause of erosions, as leucorrhœa, &c." Will Dr. Lanphear please tell us in his next issue just how he arrived at this sage conclusion?—*Indiana Med. Jour.*

IT IS said to be possible to restore one who is helplessly intoxicated, to the almost complete use of his faculties in a very short time, by administering to him a half-teaspoonful of ammonia chloride in a tumblerful of water.—*Lancet and Clinic.*

BORAX is a remedy of value in the treatment of epilepsy. It should be used in doses of from fifteen to twenty grains, largely diluted with water. Is indicated when the bromides are not well borne.

LOCAL anæsthesia sufficient for superficial operations, and continuing from two to six minutes, may be produced by spraying the part for one minute with 15 parts of ether, 10 parts of chloroform, and 1 part of menthol.

VALENTINI reports excellent results from treating diabetes with creosote, commencing with four drops each day and gradually increasing to ten.

PHENACETINE is preferable to antifebrin when a weak heart is suspected. In 7 or 8 grain doses, repeated every 3 or 4 hours, it is an effectual and safe remedy in all neuralgias.

OINTMENT FOR PIGMENT SPOTS OF PREGNANCY.—The following prescription for the treatment of cloasma of pregnancy is quoted by the *Rue de Theraputique:*

| | | |
|---|---|---|
| ℞ | Zinc oxide, | ʒ j. |
| | White precipitate, | ʒ j. ½. |
| | Castor Oil, | ʒ ij. |
| | Essence of Rose, | gtts. x. |
| | Cacao butter, | ʒ ij. |
| M | Apply morning and evening. | |

—*Med. Age.*

MR. JONATHAN HUTCHINSON uses in herpes an ointment composed of

| | | |
|---|---|---|
| ℞ | Chrysophanic acid, | ℥ i. |
| | Amoniated mercury, | ℈ i. |
| | Lanoline, | ℥ i. |
| | Benzoated lard, | ℥ vi. |
| | Liquor carbonis detergens, | gttta x. |

Ft. Ung. S. Rub the part morning and evening as required. When the part is covered with hair, first clip it closely and wash the part with Wright's liquor carb. detergens, ℥ i. to O i. of hot water.

THE question of the removal of the *Journal of the American Medical Association* from Chicago to Washington City, is being agitated. A meeting of the board of trustees has already been held to that effect. The final decision has been deferred until the meeting in May, when an expression of opinion from the profession at large upon the subject will be had. We think it folly to ask its removal to Washington, simply because it is the home of the National Government, in order that it may be designated a National Medical Journal. Washington is not, never has been and probably never will be a medical centre, and neither its location or railroad facilities recommend it.

ASIATIC CHOLERA.—Reports from the old world do not relieve us from provision for possibilities. In 1849, when Cartwright's famous twenties were on deck, we had considerable experience with cholera. The calomel of this combination might as well been thrown into the bed pan direct as through the patient. The cayenne and camphor, so far as they tended to arrouse dormant nerves were advantagous. The various measures then in vogue, had the common thought of stimulating liver and kidneys, constringing the bowels and quieting the stomach. They rarely stayed the patients march to collapse and the grave.

Profiting by the experience of '49 in the epidemic of 1853 we treated the disease as a neurosis—considering its various expressions—vomiting and purging, cramps, tremors and rapid and extreme prostration, etc., the result of irregular and faulty innervation. Treating it from this standpoint, using our remedies to rouse the dormant energies of the nervous system, and above all keeping alive the faith and hope of the patient, we saved eleven-twelfths of those who had reached collapse, while our colleagues who adopted a different pathology and treatment lost eleven-twelfths of theirs. Any one who has added to his observation a personal experience knows how thoroughly its shock depresses the nervous system and that sufficient nervous energy is neither generated or distributed to the devitalized nerve to insure normal organic action. In a recent article on cholera by Dr. Alexander Haskin (*Journal of Medical Science*, Dublin, March, 1890,) he ignores bacterial causation and reports excellent results from vesication over the line of the pneumogastric, from the mastoid process to the angle of the jaw. He believes that by thus stimulating the vagi the deranged innervation of the abdominal sympathetic is relieved.

Belief in the neurotic origin of the disease reaches beyond our observation, Dr. Henry McCormac having stated his opinion in 1834, that is was a disease of the sympathetic nervous system.

Whatever its cause, whatever its treatment, it is neither a pleasant or profitable disease for the profession. Its processes are too rapid. The important question now is, are we ready for it. Whatever its cause it delights in filth; and the city and village whose back alleys abound in decomposing organic matter, whose sewage is permitted to accumulate, whose drainage is imperfect, may expect if it reaches our shores to be decimated.

METRIC SYSTEM.—The adoption of the metric system of weights and measure, in the practice of medicine and pharmacy, is generally conceded to be only a matter of time. But a beginning must be made and it is this beginning which seems to be the principle obstructing element. It has already been pretty generally adopted in the allied sciences and apparently without the immense difficulty anticipated for its general adoption into medicine. A change in the ordinary posological tables, would of course be necessitated, but the latest authors with a view to the end in question most generally, if using the old system, give the equivalent in the metric system. With the co-operation of physician and druggist a true and scientific system, simple and easy to remember giving explanation for the minutest divisions of might or measure can be readily put in use. The system itself is certainly very simple. It is the comparison or equivalent of the two which puzzles and confuses.

KEYSEX says, "In removing cataractous lens, be sure that the fundus of the eye is normal. A diseased fundus would render the operation useless." Not always. Where the patient has had an eye enucleated and the remaining eye is cataractous with evident scotoma, many times an operation will give useful vision. When a patient is blind from cataract and desires an operation, and there is a fair projection of light, explain the condition and if they desire an operation, operate. Give the patient the benefit of the doubt.

TO OUR CONTRIBUTORS.—If you desire the JOURNAL in which your paper appears, sent to your friends, and will send us a list of the names with the post-office address, we will be pleased to accommodate you. When a number of JOURNALS are sent to the physician, sometimes he sends one or two away and the others are put on the shelf to get old, and are a loss. If sent as we suggest the result is more satisfactory all around.

## Eastern Kansas District Medical Society.

LEAVENWORTH, KAS., Dec. 28, 1890.

DEAR DOCTOR:—

The fall meeting was the largest and best ever held by this society, comparing favorably with the annual sessions of the State Society. Everything indicates that the winter meeting will be still more interesting. It will be held in Lincoln Post Hall, Topeka, January 13, 1891, beginning at 8 p. m. To insure its success, you are cordially invited to attend and bring your friends.

Fraternally yours,

W. D. BIDWELL, Secretary.

PROGRAM.

Sympathetic Ophthalmia,
J. E. Minney, M. D., Topeka.
Discussion opened by G. A. Wall, M. D. Topeka.
A Case of Picrotoxin Poisoning, with Remarks,
Edwin B. Shaw, M. D., Kansas City, Mo.
Discussion opened by W. S. Lindsay, M. D., Topeka.
Treatment of Rectal Ulceration, with Report of Case,
S. Goodwin Grant, M. D., Kansas City, Mo.
Discussion opened by W. W. Walter, M. D., Ilworth.
Purpura Hemorrhagica, with Report of Case,
F. S. Schenck, M. D., Harveyville.
Discussion opened by M. H. Cazier, M. D., Topeka
Pain, D. R. Pelton, M. D., Topeka.
Discussion opened by Jas. Lane, M. D., Leavenworth.

THE winter meeting of the Golden Belt District Medical Society will be held at Salina, Kansas, Thursday, January 8, 1891. The following is the program:

AFTERNOON SESSION.

1. General Order of Business.
2. "Report of a few cases of Complete Perineal Laceration."
W. S. Harvey, M. D., Salina.
3. "Laxatives and Cathartics, their Application,"
J. F. Brewer, M. D., Minneapolis.

EVENING SESSION.

1. "Report of a Surgical Case."
P. Daugherty. M. D., Junction City.
2. "The Therapeutic Value of Rest in Affections of the Joints,"
A. L. Blesh, M. D., Hope.
3. "Menopause; its Relation to Disease,"
J. W. Felty, M. D. Abilene.
4. "Injuries of the Eye,"
G. A. Wall, M. D., Topeka.

## Quinine.

The action of quinine in 3,961 cases of various types of disease recently published by Dr. Joaquin L. Duemas, of Havana, corresponds with our own observation, and emphasizes the fact that remittent fevers are not, as a rule, city born and bred. They are not filth diseases, but belong to localities innocent of drainage. They are paludal diseases, and prevail in districts where dampness prevails, and where the temperature permits alternating diurnal and nocturnal extremes.

While quinine is an invaluable agent, it is not good for everything. The practitioner who habitually says *malaria*, *biliousness*, quinine, is a careless diagnostician and therapeutist, and is chiefly profitable to the undertaker.

A very brief experience led Dr. D. to decide it dangerous in typhoid and other forms of septic fever, especially those of puerperal origin. He also found it injurious in the so-called typho-malarial fever, and in all adynamic fevers.

All the cases of pernicious fever in which it was freely given proved fatal, though he could not decide whether the result was *proptor hoc* or *post hoc*. It was found useless in syphalitic fever and catarrhal fevers, whether of the pulmonary, digestive or pelvic organs. It was serviceable in migraine, in rheumatism, both in its acute articular and apyretic types, in migraine, asthma and cardiac depression, and was especially useful in all forms of neuralgia, though in most diseases of non-paludal origin it was either useless or injurious.

W. L. S.

## The Dangers of Anæsthesia.

It is well known that anæsthesia is chiefly brought about by depriving, or shutting off the amount of oxygen necessary to the wants of the system; and anæsthesia is not profound or sufficient for surgical purposes until the blood is surcharged with carbon di-oxide ($CO_2$); in fact, the anæsthetic condition is one of *carbonic acid poisoning*. No matter what agent is used—if chloroform is given the danger is greater than when ether is used, as it has a very depressing effect on the heart;

while ether is, to some slight extent, a stimulant, and is safer from this fact. But should the anæsthesia be unduly prolonged this slight advantage is lost, as experiments have shown that ether has the property of destroying the red blood corpuscles, a direct damage to the blood by decreasing the oxygen carriers. Oxidation is incomplete, thus interfering with the physiological changes of the body; the system is poisoned, the nutrition is arrested, elimination of waste products prevented; the epithelium of the liver and kidneys, especially the renal epithelium is put to great strain, and in many cases the strain is so great that it gives way, and is the cause of a fatal result; so when we give an anæsthetic we are always confronted with two great dangers:

The first is death in the first stage of anæsthesia, or during the operation. Here we have the disturbing effect of the anæsthetic on the nervous centre interfering with their unity of action; this, with the primary shock of an operation, is a frequent cause of death.

The second danger we have already spoken of, and we would like to call the attention of our readers to the necessity of exercising great care in the use of these powerful agents.

Always remember that during anæsthesia the system is surcharged with carbon di oxide, that the red blood corpuscles are rapidly being destroyed, nutrition is suspended, and the elimination of waste products prevented; uræmic poisoning ensues, and a fatal result in from one to six days is as much due to the anæsthetic as if the patient had died on the table, as many autopsies have demonstrated.

We should ever have it in mind to keep the patient under the anæsthetic the *shortest* time possible; to be sure that the kidneys are in good condition, *especially* in cases where the operation is one of *expediency*.

It is also our opinion that the practice of giving a dose of opium just before administering the anæsthetic is not warranted, when we consider the action of the anæsthetic on the system. As it is well known that opium interferes with the action of the liver, blocks the kidneys, in fact restrains (if I may use so mild a word) the whole excretory apparatus, with the possible exception of the skin.

These facts should teach us to warn our patients of the danger, to discourage the use of anæsthetics for slight or trivial operations, and to guard against prolonged anæsthesia in *any* case.

S. G. STEWART.

## Peroxide of Hydrogen.

Dr. Robert L. Morris, in a paper read before the American Medical Association, advises the use of this agent in all places where pus is found. We think if this advice is followed there will be a reaction, and many will find to their sorrow that while it is an agent of great benefit in well selected cases, it will be one of harm in others. Those who have used it in ear practice know that if used freely without care, the cure is retarded; the reason is that it does not stop with pus or pyogenic membranes, but the oxidizing effects are as marked on the tissue, the red blood corpuscle is as surely destroyed as the pus corpuscle or the microbe. He advises it especially in cases of appendicitis.

We would give a word of warning against the use of this agent in recent cases where the newly-formed tissue is succulent and tender, if the peroxide is used strong enough to destroy pus and pyogenic membrane, it will destroy the newly-formed tissue, and should the protective wall that has formed around the abscess be thin, as it often is, we may be chagrined by the great harm we have done. It is an *edge tool*—handle with care.

S. G. S.

## A Chancre on the Groin.

Mr. B., came to me October 23, 1890, with a sore on the left groin. He informed me that he had had sexual intercourse with a woman in Kentucky, and although his penis remained healthy, he contracted a sore on the groin, and he took the woman to a physician and after an examination he found a chancre in the vagina. My friend being alarmed at such a condition of affairs, he came to Topeka to consult me in the matter, and I diagnosed a chancre of the groin; cause unknown, there being no urethritis present. December 7 the patient has a typical secondary syphilloderma.

WM. H. RIGHTER.

[Moral, keep away from Kentucky.—ED.]

## Pathological Society.

Quite a respectable number of the physicians of Topeka met in Dr. S. G. Stewart's office on Tuesday evening, December 15, 1890, for the purpose of arranging for the organization of a Pathological Society. It will in all probability be an auxiliary to the city society, but will hold separate and distinct meetings for the pursuance of the work belonging to such a society, and will report to the Academy of Medicine and Surgery from time to time, such reports of the work as will be of interest to the profession at large. Such a society is needed—hundreds of valuable specimens go to waste every year unexamined and unstudied. Proficiency in this branch of our work, makes good clinicians. We shall be pleased to report further progress of this new society. We wish it abundant success.

## Ergot.

It is a trite saying that "Meddlesome midwifery is bad," but none the less true. Our attention has been called, and recently, to articles in journals, to papers read before societies, advocating the giving of ergot, *as a rule*, following labor. This kind of advice is a wearyness to our flesh, as we think it nothing less than "meddlesome midwifery. Why should so powerful a drug be given in a normal labor?—echo answers, why?

Ergot is used for two purposes: First, to cause contraction of the uterus; second, to check hemorrhage by causing contraction of the vessels.

When the labor is completed, the uterus well contracted, what indication for ergot? Absolutely *none*. It should be a rule of our art that medicine should never be given, unless necessary; and we think every dose of ergot given in a labor, without complications, a positive injury. S. G. S.

"How shall we Treat our Cases of Pelvic Inflammation?" was the subject of a paper read before the Southern Surgical and Gynæcological Association at Atlanta, Ga. Nov. 11, 1890, by Dr. R. B. Maury, of Memphis, Tenn., in which he comes to the following conclusions:

1. Upon the subject of treatment the writer admitted that by non-surgical therapeutic measures large intra-peritoneal exudations are often absorbed, and even some tubal and ovarian inflammation entirely disappear, and recovery seems complete. But this is the exception, and by no means the rule.

2. For the radical cure of chronic pelvic inflammation, non-surgical treatment fails in the majority of the cases. A great many women, suffering to a moderate degree, continued to do so in spite of the best directed non-surgical measures, and, perhaps, wisely elect not to undergo operation.

3. As a rule, the only radical and permanent relief is afforded by removal of the diseased appendages. The treatment of pus-collections, of course, requires abdominal section.

"More than half the cases of metritis endometritis, salpingitis, etc., are caused by the rusty probe of the country doctor." That's the *Scotch* of it, as announced at the late meeting of the Missouri Valley Medical Society, by a gentleman from one of the new born cities of the great west. And who is this country doctor who thus inflicts untold misery upon womankind? As the buxom country woman is remarkably exempt from these disabilities, much more than half of them occur in cities and villages, and so he must sometimes invade their sacred precincts. The *country doctor*, if the term means anything, means the fellow who sat along side the other fellow at medical college, imbibed his professional nourishment from the same drugs, but when he went out into the world, was thrown upon his resources and became the evenly balanced all-round man, equal to all emergencies; able to improvise a splint or a placenta hook from a piece of rusty fence wire, to polish it and to make it antiseptic as required, and who, though his office did not contain a large display of gynecological and surgical apparatus, rarely found a case in which a forced inventive genius did not provide some more homely instrument through which he obtained about as good results as are reached by his higher favored city cousin. He was often forced to "make brick without straw," but he usually furnished his tale. He knew

that in the far away city the instrument maker could supply his wants, and he often felt the need of counsel and encouragement, but single handed and relying upon his own resources he developed an acuteness of perception, a correctness of invention, a self reliance, and strength of character rarely attained under other circumstances, and the city practitioner whose dignity is disturbed by his presence is only a professional dude.

NOTICE.—Physicians desiring their copies of the JOURNAL bound in one volume, who will send them to the JOURNAL office within the next thirty days from date, can have them bound in first-class half roan at one dollar per volume. It makes a pretty book and contains the work of the State Society, for the past two years; besides the work of a number of District and City societies, also reports of a large number of independent workers. In fact it reflects the work of Kansas physicians for the past twenty months.

ANTISEPTICS.—Surgeons are rapidly reaching the conclusion that carbolic acid, sublimate and other active germicides are not required in the treatment of *clean* wounds. If *foul*, the tyro knows they must be cleansed and made aseptic, and that they must be kept aseptic. Irrigation with sterilized warm water, or a warm solution of chloride of sodium, is all that is required even in grave operations of the abdominal cavity. The stronger antiseptics tend to produce depressed cardiac action and collapse while they produce opposite results, and do not hinder vitalization and cell proliferation.

DAVIS on the treatment of Local and General Peritonitis,—*Times and Register*—points out that peritonitis is not a "distinct disease." That the "opium splint" is irrational, for it merely locks up the products of inflammation. He gives opium and morphia in perforation. The two first indications of treatment are met by free purgation, magnesium sulphate preferably, or calomel. In perityphlitis he advocates early laparotomy, and agrees with Wylie, that should improvement not show itself after four or five days of salines, an opening should be made. In frequently repeated attacks of appendicitis he recommends complete removal. In acute septic peritonitis, as met with after child-birth, from perforation, or from bursting of an abscess, nothing but laparotomy can save life. In wounds, the abdomen should be opened at once and thoroughly explored without waiting for symptoms. Perforation from typhoid fever is a fatal accident, and operation should not be condemned without having been tried in a large number of cases. He opens the abdomen in the middle line and removes the cause, if feasible. The cavity is thoroughly douched with warm water: all adhesions broken up, and drainage-tubes introduced. In cases of excessive tympanites he does not advocate puncture with fine needles, but considers that the best way is to fill the gut with hot water, making an opening for that purpose into the ileum, if necessary.—*London Medical Recorder.*

[The above treatment has been practiced by a number of our Kansas physicians for at least three years to our personal knowledge, with remarkable success and hence we say amen to such medical gospel.—ED.]

ANTI-SMOKING.—The following is the New York law which went into effect September 1, 1890. "No child actually or apparently under sixteen years of age, shall smoke or in any way use any cigar, cigarette or tobacco in any form whatever, in any public street, place or resort. A violation of this subdivision shall be a misdemeanor, and shall be punished by a fine not exceeding $10, and not less than $2, for each offence." It doth not yet appear whether public sentiment will enforce the law.

PARK, DAVIS & CO., never weary in their efforts to advance the physicians' interest, by giving him palatable, reliable therapeutic tools to work with. We acknowledge the receipt of a sample of Saline Chalybeate Tonic, Salol & Phenacetin, Ferruginous Bland's Modified and Pil. Cascara Sagrada, Nux Vomica and Belladonna. If anything can be more perfect we would be pleased to see it.

SUBSCRICE for the JOURNAL.

# SOCIETY PROCEEDINGS.

## Topeka Academy of Medicine and Surgery.

The regular monthly meeting of the Topeka Academy of Medicine and Surgery was held at Lincoln post hall Tuesday evening, December 2, 1890, the newly elected president, Dr. T. W. Peers, in the chair.

Present — Drs. Alexander, Baily, Munn, McGuire, Limmer, McLaughlin, W. E. McVey, Righter, Mitchell, Ward, Miner, Pelton, Royce, Longshore, Minney, Lindsay, Stewart, McClintock, Magee, R. E. McVey, Sheldon.

Application for membership was made by Drs. H. M. Fagaines and W. L. Schenck.

The following committees were appointed by the president for the ensuing year:

Membership—Drs. Alexander, Lindsay and Righter.

Finance and hall—Drs. Ward, Pelton and Green

Constitution and by-laws—Drs. Munn, Lewis and Cazier

Publication — Drs. Stewart, McVey and Mitchell.

Dr. H. T. McLaughlin read a paper on "Water as a Therapeutic Agent." The author of the paper referred briefly to action and reaction in the use of therapeutic agents; how they were used and abandoned; then again taken up. Going more into detail, he spoke of many of the diseases in which water played no unimportant part in their treatment.

Dr. Sheldon referred to a recent article in the *Medical Record* in regard to the subcutaneous use of water in large quantities. It is a safe and very efficient measure. In uræmia of nephritis, typhoid state, cholera, infantile diarrhœa; in poisoning by substances eliminated by the kidneys; in cases where physiological rest of the gastro-intestinal tract is desired, as perforation of the stomach or bowels; in cases of acute anæmia from hemorrhage, contra-indicated in incipient pulmonary œdema, or the presence of severe dropsy. The water used is sterilized, blood-warm, and contains 0.73 per cent. chloride of sodium. As much as a quart of the solution can be injected in from five to fifteen minutes, and can be repeated four or five times a day. The best situation for the injection is the abdominal wall. Thorough antiseptic measures are enforced both before the introduction of the needle and in closing the wound.

Dr. Stewart added that the use of saline injections in the bowel was useful in many diseases. Washing out the stomach in indigestion is beneficial.

Dr. Royce, who had had much experience in the use of water at a sanitarium, thinks that water which does not contain medicinal agents, is about as useful as that containing those minerals. At the sanitarium with which he was connected, pure water alone, gotten from a well was used. (Dr. Royce, in addition to these remarks, stated his object in coming before the society, *i. e.*, to make known to the physicians present the fact that he was giving his time to the treatment of patients by massage, in which he is experienced.)

Dr. Righter spoke of the benefit of a glass of cold water as a laxative, and also said he drank gallons of water a day; from which we infer from the doctor's physique that water is a fat-producer.

Dr. Mitchell said water applied in the febrile conditions of children was very effectual. Related a case in which the temperature was reduced from 106° to 102° in two hours, by sponging and fanning.

Dr. R. E. McVey spoke of the use of water to reduce the temperature in typhoid fever, and asked if reducing the temperature was in the end beneficial—is the fever the disease?

Dr. Minney—If you reduce the temperature you make the patient grateful and comfortable, and to me it seems a benefit. Has not thought very favorably of the ice pack. A warm bath will often relieve the thirst in the intestinal diseases of children. As a rule we do not use enough *good* water.

Dr. Lindsay spoke of the injuries produced by the excessive use of ice water internally. Had used a sub-cutaneous injection of water once in a consumptive case, but the patient objected to a second injection, he thinking it caused an increase in the œdema of his feet. The doctor could not see that this effect was produced, still as it seemed to be of no benefit it was not repeated. The injection was readily absorbed.

Dr. Pelton thinks there is an abuse of the use of cold water on the part of many—flushing the bowels and stomach with cold water destroys the functional activity of these organs. The use of cold water externally, sponging, &c., is a dangerous procedure unless watched very carefully; it may produce internal congestion, paralysis, &c. Had often used water applied on a cloth wrapped about the body and kept wet; this acted well when the bowel rejected it continuously.

Dr. McClintock did not think favorably of the waters of Eureka Springs. Said many cases of typhoid in this city could be traced to the use of these waters.

Dr. McLaughlin defended his paper, and added that he had used ice water on cloths on the bowels in a typhoid case, and reduced the temperature from 106° to 100°. When the temperature reaches 100° quit the wet pack, sponging cloths, &c.

Dr. Ward reported in writing two cases operated upon for diseased ovaries and Fallopian tubes.

Dr. McClintock—Saw the operations, and said that the first case was one where it was difficult to tell the nature of the disease, from physical signs.

Dr. Mitchell said the first case is especially worthy of note, on account of the surroundings (a negro hut) but thorough cleansing of the patient, and asepsis during the operation, brought about the good results.

Drs. Stewart, Minney and Righter complimented the doctor on his success in the cases.

Dr. Sheldon said that in years past he had been somewhat skeptical about operations of this kind, but in the last two years his faith in them was increasing.

Dr. R. E. McVey asked if in a case of pyosalpinx, with a free discharge, whether an operation was called for. Had known cases of this kind going on for years and finally recovering.

Dr. Ward, in closing, said he used in these cases water that had been boiled. In cases where there is not much hemorrhage thought it well to leave some water in the abdominal cavity. In answer to Dr. McVey, said he would not attempt to answer in full, but thought it not advisable to delay operating.

Adjourned to meet first Tuesday evening in January, 1891.

D. F. RODGERS, Sec'y.

## South Kansas Medical Society.

### MINUTES OF NOVEMBER MEETING AT PEABODY, 1890.

PEABODY, KAN., NOV, 18, 1890.

Society met at Odd Fellows Hall, at 11 a. m. Meeting called to order by Vice-President Dr. J. W. McCracken.

Roll called and responded to as follows:

Drs. Boyd of Newton, Buck of Peabody, Furley of Wichita, Hornaday of Rock, Harris of Mulvane, Hume of Caldwell, McCracken of Sterling, Nolder of Newton, and St. John of Wichita. About twenty-five members came in after roll-call.

Minutes of last meeting read and approved.

Committee of arrangements made their report.

Two of the censors being absent, the chair appointed Drs. Boyd and St. John censors *pro tem.*

Report of treasurer and bill of secretary read, and referred to auditing committee.

Committee reported treasurer's report correct, and approved bill of secretary.

Bill allowed and order drawn on treasurer for same. Amount of bill $34 42.

Treasurer's report—Cash on hand $84 86; receipts of meeting $11 00.

Chair appointed Committee on Medical Ethics Drs. Axtell, Hume and Buck.

Petitions of L. T. Morril, graduate of Albany Medical College; of G. A. Wall, a graduate of St. Louis Medical College, and O. J. Furst, graduate of Medical Department State University, Iowa, for membership received, and referred to Censors. They reported favorable, and the gentlemen were elected members of the society.

Dr. Buck read a communication from the President enclosing the annual address, and an invitation to the Society to meet at Wichita, when the State Society should meet there in May, 1891.

Dr. Buck read the Annual Address of the President.

Moved, that the address and communication be placed on file. Carried.

Communication received from Dr. V. E. Lawrence, of Halstead, regretting inability to attend, saying he had sent his paper to Dr. Buck, asking that it be read and returned to him. (The paper failed to reach Dr. Buck.)

Dr. J. W. Felty, of Abilene, sent telegram regretting that a case of puerperal convulsions prevented his attendance.

Dr. Buck moved that the rules be suspended, and Dr. A. G. Hoffman be made an honorary member of this society. Carried.

Wichita, Kansas, was chosen as the place for holding the next meeting. The date first Tuesday in May, 1891.

Officers elected for ensuing year:—Dr. J. W. McCracken, President; Dr. L. S. Hall, First Vice-President; Dr. W. K. Harris, Second Vice-President; Dr. O. B. Whittecar, Secretary; Dr. C. C. Furley, Treasurer. The Assistant Secretary to be chosen by the Secretary, so that they shall reside at place of holding meeting.

Society adjourned to meet at Wichita first Tuesday in May, 1891.

W. K. HARRIS, M. D.,
Secretary.

## Central Branch Medical Association.

The Central Branch Medical Association held its regular meeting at Greenleaf, Kansas, Thursday, December 4, 1890.

Present—Drs. Chase of Irving, Humfreville of Waterville, Armstrong of Axtell, Gardner of Greenleaf, Green, Jacobs and Andrews of Washington, Reding of Vermilion, Manz of Linn, Wallace of Palmer, Cullimore of Atchison, and Sawhill of Concordia.

Dr. Chase presented interesting cases of skin diseases for diagnosis. These cases were thoroughly examined, the diagnosis and treatment discussed.

Dr. Armstrong reported a case of a woman aged 56, who had ceased to menstruate at the age of 43. In February, 1890, her menses returned, and she has menstruated regularly once a month since. She has good general health, in fact better than she has had for some years.

Dr. Humfreville read a paper on "Plaster of Paris Dressing in Fracture of Femur in Children." This paper was fully discussed.

The Association adjourned to meet at Greenleaf, Kan., the first Thursday in March, 1891.

W. F. S.

## The Missouri Valley Medical Society.

The Missouri Valley Medical Society met at the Coates House, Kansas City, at 10 a. m., December 18, 1890, the president, Dr. J. M. Richmond in the chair; Secretary Thomas at the desk. About fifty physicians present.

The board of censors reported favorably on the following named physicians for membership:—Drs. A. H. Cordier, McPherson, Kansas; Henry Z. Hissem, Ellsworth; J. P. Lewis, M. B. Ward, J. E. Minney, Topeka; J. S. Foote, S. M. Bibbe, Wichita, Kansas; Geo. W. Davis, M. A. Bogie, C. F. Wainwright, J. D. Griffith, J. F. Bennie, Kansas City, Mo.; H. P. Duffeld, Shenando, Iowa; Paul Paquin, Columbus, Mo.; E. E. Rankin, McLouth, Kansas; J. M. McClanahan, Guilford, Mo.; J. T. Marsh, Liberty; L. Bremer, St. Louis; Z. T. Martin, Lathrop, Mo.; W. W. Daugherty, Liberty, Mo., who were duly elected.

The first paper was by Dr. J. S. Foote, of Wichita, Kansas, on "The Lymphatic System." Owing to the numerous cuts and diagrams, (about fifty) prepared by the doctor, which were admirably executed, and to which he had to constantly refer, he was compelled to deliver the report extemporaneously. It was well done.

The Doctor asked three questions, viz.:

1. What is the lymphatic system?
2. Where is it?
3. What does it do?

In answer he said:

1. It was a system of spaces.
2. It was everywhere.
3. It was strictly nutritive.

The report was discussed by Drs. Sharp, Coffaman and Loeb.

The paper was so complete that it required no discussion.

Adjourned to 2 p. m.

2 p. m. The meeting reconvened with about sixty physicians present.

Dr. Hal Foster, of Kansas City, read a paper on "Complete Adhesion of the Soft Palate to the Pharynx, with an Operation for Its Cure," (which see on page 13 of this number of the JOURNAL.

Dr. Mrs. E. Stedwell, of Omaha, read a paper on "Scientific Training of Mothers."

She advocated triune development, viz.: Intellectual, moral and physical; more play and less school. The school was the place for systematic training in hygiene and physiology. Child-bearing was a question of muscle and not of brains. Ignorance on the part of the mother caused her a great deal of suffering, and caused her to shun child-bearing.

Scientific motherhood is coming, and child-bearing must be made reasonably easy and attractive. 400,000 infants die yearly in the United States, and a great many of them through ignorance, and especially of feeding.

The nursing should be done by the mother; it saves her by preventing conception, and saves the child. The highest education prepares woman for motherhood. Every child has the right to be born well.

DISCUSSION OF THE PAPER.

Dr. M. B. Ward—There should be more care in making and executing the rules in our common schools; very many of them are obnoxious because cast iron. The discipline is not sufficiently humane.

Dr. J. Bell—Criminality is more common amongst the educated than the ignorant. I have letters from physicians all over the country, in answer to letters I had written respecting the frequency in which abortions were produced. Physicians and preachers are greatly at fault in this matter. They are afraid to raise their voices against this abominable sin.

Dr. Minney—I do not think that criminality is more frequent among the educated than the ignorant, but less. It is among the luxurious, educated or uneducated. Physicians are not guilty of the heinous crime of which Dr. Bell speaks; it is criminals.

Dr. Allen—Education refines, elevates, but does not degrade. If education has the effect Dr. Bell says it has, our schools and colleges should be closed, and the sooner the better.

Discussion closed.

Dr. Bremer presented a brain tumor weighing two ounces, (probably the largest ever removed from a brain. with recovery of the patient), oval celled sarcoma. The patient had a good history; about eight months ago the patient had weakness of the right hand, afterwards the arm became almost useless. He was treated with the Faradic current. Up to the time of the operation, ten days ago, he had nine epileptic spasms, without loss of consciousness, but great pain felt; there was weakness of the leg and twitchings of the orbicularis. His health remained good and his intellect unimpaired. He gave history of being dragged by a horse and getting his shoulder hurt, and attributed the difficulty to this injury, but it had nothing to do with it. The symptoms pointed to central lesion of the left hemisphere; there was also atrophy of the arm and leg; the lesion was a destroying and a discharging one; radiation to the arm and leg showed cortical lesion. (Here the doctor drew a diagram.) The single symptom which enabled us to locate the tumor, and not only locate it but map out its exact size, was the contraction of the thumb and two fingers during the spasm—the thumb and two fingers' symptom. The only complication was the excessive hemorrhage during the operation, caused by abnormal development of the vessels in the bone due to stasis. (Here the doctor presented the specimens of bone, the tumor being presented at the beginning of the report.)

DISCUSSION.

Dr. Lamphear—This case shows that we should not always be guided by the history of the case. The injury received at one time by this patient evidently had nothing to do with the formation of the tumor. I have a patient now suffering with tumor of the brain. The mode of invasion is just the opposite. There was first slight pain in the side of the face, followed by spasms. In two weeks the side of the neck was affected; in three weeks flexion of forearm and hand. After the last three spasms aphonia followed. These symptoms following each other so quickly shows that the tumor is growing rapidly. These cases are fit subjects for operations. I will operate on this man to-morrow, and any of you who

are interested are welcome to witness the operation.

Dr. McClintock reported some cases of trephining for imbecility and eyilepsy, and advocated the operation in well selected cases.

Dr Bremer, in closing, said there were present two symptoms of brain tumor, Jacksonian epilepsy and paralysis; but no vertigo, no headache, no vomiting, no neuritis, and only a slightly congested papilla, hence the symptoms were in the minority.

Dr. Bremer also read a paper on "Remarks on the Morphine Habit and its Treatment." Some of the points in the paper were:

1. The medical profession suffers most.
2. Cautioned against too frequent hypodermic morphine medication.
3. The syringe can be dispensed with.
4. The ease with which morphine can be obtained by druggists, nurses and physicians, is one reason why so large a number are addicted to the habit.
5. The moral contagion. In some countries the caste of society is determined by the morphine skin.
6. Some cases of morphineism lead to insanity; cocaine always does.
7. In the treatment we should not seek for a substitute, but for nurses, physicians, and proper surroundings.
8. Deception and false statements should not be practiced on the patient. The patient should not know the dose nor the treatment.

DISCUSSION.

Dr. Crowell attributed the increase of morphineism to the hypodermic syringe. He does not use morphine so frequent as he formerly did. He uses it at one time always, and that is just preceding the administration of an anæsthetic.

Dr. McCra—One class of morphine eaters I desire to speak of, and that is pregnant women. Their children when born look well, but in very many instances they wilt and die in a few days without any appreciable cause. Three cases came under my observation; two of them died, and at the time I did not know the cause. The third one—all of one mother, (having learned in the meantime that the mother was a morphine eater) about the fourth day began to show signs of weakening, and I fed it for three weeks on small doses of morphine, with good results—it lives.

The next paper was by Dr. Allen, "Acute Atrophy of the Liver, with report of a Case."

Dr. Hanu W. Loeb read a paper on "Atrophic Rhinitis, and how Physicians can treat them;" He advocated cleansing the mucous membrane thoroughly with Dobell's solution, or some equally as good cleansing agent, and then medicate the parts with

| | | |
|---|---|---|
| R | Menthol | gr. x. |
| | Liquid Alboline, | ℥ i. |
| H | Sig. Spray the nose once a day. | |

DISCUSSION.

Dr. Christy—Owing to the other cares and responsibilities of the physician, he cannot have the time to do this work. He cannot make his calls, and attend to calls at all hours, and meet engagements with these catarrhal patients.

Dr. Thomas—The crotchet hook wrapped with cotton is a good instrument to clean the nose with.

Dr, Foster—Patients should be taught to treat themselves. The hot water douche morning and evening is a good stimulant and cleansing agent to the mucous membrane. I am not so afraid of the douche causing middle ear trouble as in former years. Liquid benzonal is a pleasant cleansing agent.

Dr. Bailey—I endorse Dr. Loeb's treatment. Patients should be taught to keep the nose clean. If they would catarrhal troubles would be less frequent.

Dr. Loeb, in closing said the general practitioner has time. He will treat the uterus; has set times for patients to meet him; his other duties do not interfere with his office practice but little in such cases, and why not in atroph rhinitis. The general practitioner can treat these cases, and is responsible for his patients running after advertising quacks and patent nostrums in a great measure, because he will not treat these minor but essential troubles in his patients.

Evening session, 7:30, p. m. About sixty-five physicians present.

Dr. Crowell read a paper entitled "Are the Uterine Appendages too frequently Extirpated?" The conclusion was that they were not. This of course meant in properly selected cases.

The paper was a good one and listened to attentively.

DISCUSSION.

Dr. Ward opened the discussion—He confirmed the sentiment expressed by Dr. Crowell, and presented some beautiful specimens of pus tubes, which consisted of cysts or sacks of pus, with strong adhesion, giving the history of cases operated on with gratifying results.

Dr. Gantz—I agree in the main with the paper.

Dr McCra agreed with the paper substantially, but thought that the dirty sound of the *country* practitioner caused the peritonitis in many instances.

Having so recently been a country doctor, and our train being due, we made our exit.

## A Sand Burr in the Œsophagus.

November 27, Thanksgiving day a gentleman came to my office with a sand burr in the œsophagus, as far down as I could reach with the index finger. After it was located I passed a pair of forceps designed only for removing foreign bodies from that situation, and removed it. The burr was stuck to a finger of one hand, and he knew that if he removed it with the other hand it would stick, he removed it with the teeth and probably by a sudden inspiration he swallowed it.

This is not like a case reported by a homœpathic surgeon of Topeka, who read an interesting case of the successful removal of a sand burr, and several days afterwards the patient vomited up the burr.

I removed the burr, and the patient wanted to keep it as a relic which I permitted.

WM. H. RIGHTER.

[Moral, patronize a physician.—ED.]

## Hypodermic of Tartar Emetic.

IN A CASE OF ATTEMPT AT SUICIDE.

Mrs. J. S., in August, 1880, took arsenic and chloral hydrate for the purpose of ending her existence. I was called to see her but could not administer medicine as stated above. I returned to my office for the purpose of taking my hypodermic syringe, and as I could not find apomorphia in Topeka I had made a solution of tartar emetic five grains to water ʒj.

I administered this hyporderma tically in two doses; one in right fore arm and one in left arm, and emesis occurred in 30 seconds, and in two hours emesis occurred again, and the patient continues to live. Pustulation occurred beautifully by the effect of the tartar emetic.

I do not wish to recommend tartar emetic hypodermatically, but I will use it again if I ever have an object in view, and can not get what I want at the time and have such an obstinate case to deal with.

WM. H. RIGHTER.

THE lawyers of St. Louis are striving to prevent Dr. Porter of that city from receiving his bill for medical attendance on the late Henry Shaw, the famous benefactor of "Shaw's Gardens" fame. We hope to see the doctor get his fee and a good one; there is no doubt that the lawyer will get his fee, sure. It is not always the poor man who doesn't pay his doctor bill.

PRELIMINARY capsulotomy in the extraction of cataract as described by Dr. T. J. Tyner of Austin, Texas, in the November number of Daniel's *Texas Medical Journal*, consists in thrusting a Bowman stop-needle into the anterior chamber of the eye—the pupil having been previously dilated—the point of which, and also the entire field of the incision, are in full view. The apsulecsi now lacerated in its upper quadrant, the line of incision corresponding to the upper pupillary curve of the iris. In this manipulation and in withdrawing the needle, the greatest care should be observed that no aqueous is lost. The eye is now practically undisturbed and as favorable for the corneal section as before, which is to be done quickly, using a grasp knife, preferably rather broad. When the section is finished, pressure with the flat of the blade causes the corneal opening to gape; when at the same moment counter-pressure with the fixing forceps below aids the expulsion and the lens glides out through the still open pupil with surprising ease.

## Inoculations of Koch Lymph in New York.

CASES AT ST. LUKE'S HOSPITAL.

SERVICE OF DR. E. P. KINNICUTT.

Up to the present date fifteen patients, suffering from various forms of tubercular diseases, have been inoculated by Dr. Kinnicutt with Koch's lymph in the wards at St. Luke's Hospital.

The cases were carefully selected, with the view of thoroughly studying this method of treatment. All of them will remain under his personal observation in the hospital during the entire period of treatment, and a detailed report of their histories subsequent to inoculation will be published from time to time.

Two cases of lupus of the face, one case of lupus of the hand, accompanied by tuberculous infiltration of a limited portion of one lung; two cases of tuberculous glands (cervical;) three cases of hip-joint disease with intermittently discharging sinuses; one case of tuberculous disease of tibia and fibula with open sinus; one case of prostatic surface tubercular disease; four cases of pulmonary tuberculosis in its first stage and limited in area; one case of doubtful diagnosis, are embraced in the above group.

QUANTITY OF LYMPH USED.—Thus far 0.001 gm. of the lymph has been used for the initial inoculation in all adult cases, and 0.005 in children.

Decided reactions have been obtained in all patients but one of the fifteen inoculated. The reactions have varied in the time of their appearance from four hours after inoculation to twenty-four; also in their intensity and duration.

REACTIONS.—The longest duration of the reaction has been forty-six hours. The highest temperature recorded during reaction has been 104°. The increase in pulse and respiration rate has been proportionate to the rise in temperature. The local changes in the cases of lupus have corresponded very exactly with those recorded by the Berlin observers, and have been of the greatest interest. The differential diagnosis in the doubtful case mentioned, lay between lupus of the throat and tertiary specific lesion. No reaction followed the inoculation of 0.001 gm., and a second of 0.002 gm., and the case was accordingly regarded as one of specific disease.

"No symptoms which could occasion any apprehension have been observed in any of the cases.

"Tables are appended showing the symptoms and signs observed, during and following the inoculations, in three patients presenting different forms of tubercular disease.

Case I. Phthisis.—Female, aged forty. Tubercular infiltration of apex of right lung. Sputa contain very numerous tubercle bacilli. No rise of morning or evening temperature during the two weeks previous to inoculation. General condition good.

"First inoculation, December 10th, a. m., 0.001 gm. Reaction developed five hours after inoculation, slight chilliness, headache, general malaise, fever. Duration of reaction, twenty-one hours. Highest temperature, 101.2° F. Amount of sputa for twenty-four hours preceding inoculation, 11 drachms; for twenty-four hours following inoculation, 13 drachms; for second twenty-four hours following inoculation, 18 drachms; for third twenty-hours following inoculation, 3 ounces. Urinary examination, a trace of albumin present before and after inoculation. Physical signs: Crepitation over affected area more marked, with numerous rales in larger tubes of same. No enlargement of spleen.

"Second inoculation, December 13, 3 p. m., 0.001 gm. Reaction developed thirteen hours after inoculation. Duration of reaction, nineteen hours. Highest temperature, 101.2° F., seven hours after beginning of reaction. Amount of sputa for twenty-four hours following inoculation, 3 ounces. Urinary examination, trace of albumin, otherwise negative. Physical signs: Bronchial element of respiratory murmer distinctly more marked, and physical signs of infiltration obtained over an increased area. No enlargement of spleen.

Third inoculation, December 16, 3 p. m., 0.001 gm. Reaction developed six hours later; chilliness, nausea, and fever. Duration of reaction, thirty hours. Highest temperature, 103.8° F., eighteen hours after inoculation. Amount of sputa, two ounces. Physical signs-

Numerous moist rales in large tubes of affected area, abundant subcrepitation. No enlargement of spleen.

"Case II. *Prostatic Surface Tubercular Disease.*—First inoculation, December 11, 3:30 p. m., 0.001 gm. Temperature normal. Reaction developed seven and a half hours later; rigors, headache, pains in limbs, general malaise, fever, Duration of reaction three hours. Highest temperature, 104° F. Local symptoms, pain and uneasiness over region of bladder, increased irritability of same. Urinary examination, small amount of albumin present before inoculation distinctly increased during reaction.

"Second inoculation, December 13, 3:30 p. m', 0.001 gm. Reaction developed four hours later. Duration of reaction, thirty hours. Highest temperature, 101⅘° F. Local symptoms similar to those following first inoculation. Urinary examination same as above with a few hyaline casts. Physical signs:

"Third inoculation, December 16, 3:30 p.m., 0.001 gm. Reaction developed five hours later; rigors, headache and fever. Duration of reaction, twenty-nine hours. Highest temperature, 103.8° F. Physical signs: Severe pain felt at base of penis. Great irritability of bladder, the urine being ejected every fifteen or twenty minutes through supra-pubic opening.

"Case III. *Lupus of Ear and Contiguous Portions of Face and Neck, of Twelve Year's Duration.*—Female, aged twenty-two. Under treatment for the greater portion of this time. First inoculation, December 11, 3 p. m., 0.001 gm. Temperature normal Reaction developed, nine hours later. Slight rise of temperature and burning sensation in affected ear. Duration of reaction, twenty-one hours. Highest temperature, 99.8° F. Local signs described in appended notes. Urinary examination negative. Physical signs, no enlargement of spleen.

"Second inoculation, December 13, 0.002 gm. Reaction developed eleven hours later; slight fever, decided burning sensation in affected ear. Duration of reaction, twenty-two hours. Highest temperature, 100.6° F. Local signs described elsewhere. Urinary examination, trace of albumin, otherwise negative. Physical signs negative. No enlargement of spleen.

"Third inoculation, December 16, 0.003 gm. Reaction developed six hours later; nausea, headache, chilliness, and fever. Duration of reaction, thirty hours. Highest temperature, 103.8° F. Local signs: more or less sero purulent exudation which crusts rapidly; crusts cover nearly the entire affected area. Hyperæmic areola, more than an inch in width, surrounds the entire patch. Posterior margin of patch presents a raw fissure as if the morbid tissue were separated from the healthy skin.

"The local changes observed in the case of lupus are described as follows by Dr. George H. Fox, by whom the patient was referred to me.

NOTES BY DR. GEORGE H. FOX OF CASE III, LUPUS VULGARIS OF LEFT EAR.

On December 11, at 3 p. m., (date of first injection of lymph,) the case presented the following appearance:

The left auricle was considerably thickened, of a dull red hue, and partly covered by adherent flakes of dead epidermis. Below the ear was a rounded, circumscribed patch of lupus, about the size of a silver dollar, the smooth surface of which presented well-marked cicatricial lines, the result of previous scarification. This patch extended for a short distance up behind the ear. Between the lines, the dull-red hue of the lupus tissue was still apparent. During the patient's two weeks residence in St. Luke's Hospital there had been no sensation of pain, burning, or itching in the affected part. On December 12, 3 p. m., there was so marked a change in the appearance of the ear, that it was noticeable at first glance, even at a distance.

The affected part appeared as though it were acutely inflamed or erysipelatous. The auricle had assumed a brighter red hue and was considerably swollen. The patch beneath and behind the ear was notably elevated, and the redness had increased to such an extent that the cicatricial appearance of the surface was no longer apparent. At the margin of the patch there was a narrow zone of hyperæmia, and a number of prominent red points which had not been noted on the preceding day, and which doubtless indicated the most recent infiltration of the healthy tissue. The patient

stated that a burning sensation had occurred during the previous night, and the ear had felt quite painful toward morning. It now felt as it looked, swollen and inflamed.

On December 13, the elevation of the patch and swelling of the auricle had subsided, and the color was less inflammatory. The burning sensation had gone. The epidermic flakes, especially upon the helix of the ear, were dry and whitish. At a single point on the patch below the ear, a serous exudation was noted. A second injection of the lymph was made.

On December 14, there was not much change in the affected part. There was a slight increase of inflammation, but by no means so marked as after the first injection, although double the dose had been employed. There was no elevation of the margin of the patch, and the lobe of the ear felt a trifle softer. Below and behind the ear there was a slight moist discharge, with a tendeney to honey-like crusting.

The patient stated that during the previous night she experienced "a heavy, stupid, sick feeling," and felt a sharp pain in the ear, as after the first injection, but the sensation of burning and swelling was much less this time.

On December 15, it was simply noted that the surface of the affected part presented more of an eczematous appearance.

The diagnosis of tubercular disease of the prostate in Case II. was made by Dr. Keys, by whom the patient was referred to me. The reaction obtained would seem to be corroborative of this diagnosis.

## The Appendix Vermiformis.

BY JOHN FERGUSON, M.A., M. D., L.R.C.P. EDIN.

The following observations have been made during the past eight years, and cover a total of two hundred dissections, carefully performed for the purpose of elucidating certain points regarding this small and apparently unimportant bit of the human body.

The average length of the two hundred appendices was four and one-half inches; and the average diameter that of a No. 9, catheter, English scale. In three cases the appendices were only half an inch in length; while in only one case could it be said that it was entirely absent.

Of the entire two hundred examples, the appendix was supplied with a mesentery of its own, and so placed that perforation would open directly into the peritoneal cavity, in one hundred and twenty-three. Of these one hundred and twenty-three, the appendix lay to the right of the cæcum in nineteen, descended downward in eleven, lay inward from the cæcum in eighteen, and behind the cæcum in the remaining seventy-five.

The other group of seventy-seven cases was specially interesting in the fact that the appendix was so placed and covered by peritoneum that its perforation would open into the subperitoneal tissue, and establish a diffuse form of cellulitis. In these cases the most likely course for the pus to pursue would be downward, and finally to present itself in the situation of a psoas abscess. One case is of great interest. A man of about forty, who had a discharging sinus in the above situation died of an acute attack of pneumonia. A soft catheter could be passed up this sinus a distance of ten or eleven inches. On making a careful dissection of the sinus, it was traced to a perforated appendix, that lay behind the peritoneum in the position of the above seventy-seven. In reality this case was an example of a fæcal fistula.

Out of the two hundred cases examined there was evidence of old-standing lesions and perforations in seven. In three of these latter the proof, that at some prior date there had been a perforation, was quite positive.

Foreign bodies were found in fifteen of the two hundred. There were enteroliths in two; a small stone in one. a small bone in one; a piece of a screw nail in one, and such articles as orange-pips, cherry-stones, etc., in the other ten.

The above remarks are of some importance in showing that of the two-hundred appendices, there were foreign bodies in fifteen; and that there were good signs of lesions in seven; three clearly having been of the character of a perforative appendicitis. This is very important, as pointing to the possibility of recovery after such a lesion of the appendix.

Subscribe for the MEDICAL JOURNAL.

## Mosquera's Food Products—Beef Meal, Beef Cacao.

Parke, Davis & Co., whose reputation for original work has long been established, announce that after thorough study of the various food products they can now supply preparations which will fulfil all the requirements for therapeutic and dietetic use.

Physicians, in their practice, very frequently meet with cases where nutrition is of more importance than medication, in fact, cases where nutrition is the only agent they can count upon. The question of replacing the waste of tissue, where normal nutrition is inefficient, by means of concentrated or predigested foods, is one that always presents many difficulties, there being very few preparations, if any, that meet all the requirements of the medical profession.

All the difficulties heretofore encountered by the medical profession in the use of predigested foods, have been overcome by the new food products of the Mosquera-Julia Food Company.

Mosquera's Beef Meal contains all the stimulating principles of the extracts of meat, and in addition, the nutritive principles which the extracts lack; all the albumen of meat juices without their weakness; all the strength of powdered meats without their rancidity and insolubility; all the peptone of the peptonized meats without their bitterness.

The claims we make on behalf of Mosquera's Beef Meal, therefore, cannot be over estimated; they are based on its analysis and properties, and may be condensed as follows:

Mosquera's Beef Meal is a perfectly pure predigested meat, containing all the nutritious constituents of good lean beef, half of which are in soluble form, ready for immediate assimilation, and the other half easily digestible by the gastric and pancreatic juices. Therefore the entire preparation, being practically dry, is composed of nutritive matter, containing about 40 per cent. of soluble peptone and albuminose.

It represents, in actual nutritive value, at least six times its weight of good lean beef.

It is perfectly palatable, and will be tolerated with ease by the most delicate stomach.

It admits of being administered in a variety of forms, thus avoiding monotony in the food.

It is the most nutritious as well as the most economical concentrated food.

To physicians interested a pamphlet fully descriptive of the special advantages, uses and methods of administration of these preparations will be mailed on request, and samples will be sent to physicians who desire to clinically test them in practice.

## Reprints Received.

"Malaria and the Causation of Intermittent Fever." By Henry B. Baker, M. D., of Lansing, Mich.

"Abstract of Proceedings of the Michigan State Board of Health."

---

ACUTE febrile conditions:

| | |
|---|---|
| Potass citras | ℈viij. |
| Wormwood verat. | gtts vxj. |
| Fl. Ext. gelsem. | ℥j. |
| Spts. nitre dulc. | ℥s. |
| Simple spr. gr. ad. | ℥ij. |

M. Sig. D. A teaspoonful every hour until fever subsides.

---

"AM now convinced after testing its virtue in some exceedingly severe and obstinate cases, that Tongaline possesses decided and marked curative properties in Rheumatic Neuralgia and also many instances of Muscular Rheumatism." WALTER COLES, M. D.,
St. Louis, Mo.

---

"AM more than pleased with the results of Ponca Compound, having used it for several cases of uterine displacements, which began to improve from the first day the remedy was taken." J. H. NAFTEL, M. D.,
Pine Level, Ala.,

---

AFTER one years absence from the state, soaking himself full of medical knowledge, Dr. Gaston Boyd has returned to his home at Newton, Kansas, to enter with renewed zest into the practice of medicine. The Doctor will be better prepared than ever before for the work, and we hope to hear from him through the columns of the KANSAS MEDICAL JOURNAL.